

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Dr. Peter Guhl, PLC & Assoc. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices from Dr. Peter Guhl, PLC & Assoc.

I authorize the following individuals to obtain information regarding my care, including but not limited to my diagnosis, treatment and appointment dates and times.

<b>NAME</b>	<b>RELATIONSHIP</b>
_____	_____
_____	_____
_____	_____

I understand this acknowledgement and release will remain in effect until written notice is given to Dr. Peter Guhl, PLC & Assoc.

_____	_____
<b>Signature</b>	<b>Name of Patient(PRINT)</b>

_____	_____
<b>Signature of Patient Representative</b> (required if the patient is a minor or an adult who is unable to sign this form)	<b>Relationship of Representative to patient</b>

\_\_\_\_\_

Date

Revocation Date\_\_\_\_\_