Atlantic Otolaryngology

Michael Widick, MD

333 Cocoa Beach Causeway
Cocoa Beach, FL 32931
321-799-9797

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient: ______________________________

Signature of Patient: ______________________________

Date: ______________________________

Patient's Date of Birth: ______________________________

Patient's ID/Chart Number: ______________________________

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: ______________________________

Describe Personal Representative Relationship: ______________________________
(parent, guardian, etc.)

Signature of Personal Representative: ______________________________

Date: ______________________________

For Practice Use Only:

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Signature of Practice Employee Date

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