

JOYCELYN M. THEARD, M.D., P.A.

Acknowledgment of Receipt of Privacy Practices

By signing this document, I acknowledge that I have been given the opportunity to review Joycelyn M. Theard, M.D., P.A.'s Notice of Privacy Practices prior to signing this document, which explains in further detail how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices of Joycelyn M. Theard, M.D., P.A.

Print Name:

Signature:

Date: _____

Dr. Theard's *Office* Use Only

Date acknowledgment received: _____

Staff Initials: _____

OR

Reason acknowledgment was not obtained: _____
