NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We maintain a record of the health care services we provide to you. You may ask to see and/or copy that record. You may also ask to correct that record. We will not disclose or share the contents of your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. You may get more information about your record by contacting the Office Manager.

By my signature below I acknowledge receipt of the Notice of Privacy Practices for Cheryl M. Yokoyama, M.D., P.S.

____ ____________________________
Patient or legally authorized individual signature   Date   Time

____
Printed Name

____
Staff Witness

This form will be retained in your medical record.

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