Acknowledgement of Receipt of Notice of Privacy Practices

Jeffrey B. Mundorf, MD, Inc.
Michelle C. Cordova, PA-C

Central Coast Gastroenterology Medical Group

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Patient authorization for use and disclosure of protected health information

By signing this authorization, I, _____authorize Jeffrey Mundorf, MD to use and/or disclose certain protected health information (PHI) about myself to:

_____
(Name of person, friend or family member or entity to receive this information, not your physician)

This authorization will expire on _____or LIFETIME.
(Expiration Date or Defined Event)

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient
_____ Guardian or conservator of an incompetent patient
_____ Beneficiary or personal representative of deceased patient

Name of Patient:_____