1960 Family Practice, P.A.

Acknowledgement of Review
of
Privacy Practices

I, the undersigned, have reviewed the Insight Digital Imaging Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Privacy Practices.

______________________________   ______________
Signature of Patient or Representative   Date

____
Print Name of Patient or Personal Representative

____
Capacity of Personal Representative
(Parent, Guardian, Trustee, Executor)

____
Address

____
City, State, Zip Code