ARMANDO J. JARQUIN, M.D., P.A.

Notice of Privacy Practices
Patient Acknowledgement and
Patient Agreement for Health Care

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

I hereby voluntarily consent to any diagnostic procedures and treatment by Armando J. Jarquin, MD, PA, as may be necessary in my physician's judgment. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made to me as to result or cure. This form has been explained to me, and I certify that I understand all its contents.

I authorize Armando J. Jarquin, MD, PA to release my private healthcare information to the following person(s) in case needed:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____