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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, acknowledge that I have received a copy of Breakthrough Medicine's Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual signature Date

_____
Printed Name (or print parent, legal guardian, personal Representative)

I acknowledge and agree that that Breakthrough Medicine may disclose my protected health information to the following persons, each of who is directly involved in my care:

1._____

2._____

3._____

4._____

I acknowledge and agree that Breakthrough Medicine may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to Breakthrough Medicine.

_____ _____
Patient or legally authorized individual signature Date

_____
Printed Name (or print parent, legal guardian, personal representative)

For office use only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):