

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I understand the Notice of Privacy Practices for Chautauqua PT, OT & SLP Professionals, PLLC. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Chautauqua PT, OT & SLP Professionals, PLLC to release any of my protected healthcare information.

Patient's or Authorized Representative's Printed Name & Date

Patient's or Authorized Representative's Signature