



Acknowledgment of Receipt of Privacy Policies and Office Practices

By signing below, I attest that I have received notice of the Privacy Policies and Office Practices of Sarah Fishman MD, PhD PC on the date indicated. I understand any questions I have regarding these privacy and office policies may be directed to the patient privacy officer indicated in this notice.

Printed Patient Name: _____

Patient Signature: _____

Patient's Representative Signature: _____

Relationship to Patient: _____

Date: _____