NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION HANDED TO YOU CAREFULLY.

By signing below I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

Signed: Date: ____/_____/____
mm dd yy

Printed name:

Form: NTCPRIV2009E1