Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of Century Clinical Family Medicine, LLC., detailing how my information may be used and disclosed as permitted under federal and state law.

I authorize Century Clinical Family Medicine, LLC to discuss my medical information with the following individuals:

Name: _____Relationship:_____ phone number_____

Name: _____Relationship:_____ phone number_____

Name: _____Relationship:_____ phone number_____

Signed: _____ **Date:** _____