CapitalCare Medical Group

Notice of Privacy Practices Acknowledgement and Consent

CAPITALCARE MEDICAL GROUP

By signing below, I acknowledge that I have been provided a copy of the CapitalCare Medical Group Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by CapitalCare, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Relationship

Or Authority