

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICE –DR. DAVID YABLONSKY**

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practice describes the uses and types of disclosures of my protected health information that might occur throughout my medical treatment, payment of bills or in the performance of Dr. David Yablonsky's health care operations. The Notice of Privacy Practice also describes my rights and Dr. David Yablonsky's duties with respect to my protected health information. The Notice of Privacy Practice is available at Dr. Yablonsky's office.

Dr. David Yablonsky reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices upon a written or verbal request.

Signature of Patient or Personal Representative

Printed Patient Name or Personal Representative

Date

Description of Personal Representative's Relationship