TRISTATE ARTHRITIS AND RHEUMATOLOGY
AND ITS AFFILIATED COVERED ENTITIES
ACKNOWLEDGMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Tristate's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice by calling 859-331-3100, by visiting Tristate's website at www.tristatearthritis.com or by requesting one at Tristate.

SIGNATURE:_____ **DATE:**_____

I authorize the office of Tristate Arthritis & Rheumatology to discuss my medical information, i.e., diagnosis, lab results and test results, with the following people listed below:

Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**

If you are not the patient, please fill out the following information:

Name:_____

Relationship to Patient:_____

Address:_____

Telephone:_____

Please furnish a copy of any conservator/guardianship papers with this form.