IMC-Eastern Shore Family Practice

Acknowledgement of Receipt of Privacy Practice

You acknowledge that you were offered a copy of our Notice of Privacy Practices. If you would like to receive a paper copy at any time in the future, you may call (251)626-1175.

Patient Name:_____
(please print)

Signature of Patient (if over 14 years of age):_____

Signature of Parent/Guardian (if under 14 years of age):_____

Date:_____

We will only release information with a completed and signed Release of Information. However, you may designate individuals that we may discuss your health care with. Please list those below.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____