Dr. Darlene Powell Garlington
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at the phone number above.

If you have any questions about my Notice of Privacy Practices, please contact me at the address and /or phone number above

I acknowledge receipt of the Notice of Privacy Practices of Dr. Darlene Powell Garlington.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

Signature: _____ Date: _____
(patient/parent/conservator/guardian)