ACKNOWLEDGMENT OF RECEIPT

I __________________________________, acknowledge that I received a copy of

Dr. Serino and Dr. Schefferly's Notice of Privacy Practices.

I hereby authorize the office of Dr. Serino and Dr. Schefferly to release any and all information

regarding my case to ____

Name of Family Member/Care Giver

for patients 18 years and older

____ _____________________

Signature of Guardian/Patient 18 years and older Date