Acknowledgment of Receipt

I ___________________, acknowledge that I received a copy of Dr. Schefferly and Dr. Arnold's Notice of Privacy Practices.

I hereby authorize the office of Dr. Schefferly and Dr. Arnold 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