ACKNOWLEDGMENT OF PRIVACY PRACTICE AND AUTHORIZATION FORMS

I have read and understood Dr. Myra C. Luna's Notice of Privacy Practices as well as the Authorization for Release of Identifying Health Information. I am signing voluntarily.

Date _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____

Print Name _____ Signature _____