Concorde
Medical Group PLLC

Notice of Privacy Practice Acknowledgement

For the patient's personal protection, the state of New York requires that each patient acknowledge, in writing, that they received a copy of the practices Notice of Privacy Practice.

Please be kind enough to sign below:

"By signing below, I hereby acknowledge receipt Concorde Medical Groups Notice of Privacy Practice."

_____

First Name MI Last Name

_____

Patient Signature Date

"I acknowledge that the practice may use and disclose my "Health Information" for the purposes of treating me, obtaining payment for services rendered to me, and performing routine healthcare operations and services in this practice."