Myers Podiatry Clinic

W. Charles Myers, DPM

Acknowledgment of Receipt of Privacy Policy

I,____________________________ hereby acknowledge receipt of the "Notice For Policies" provided by this medical practice.

I am the: (circle one) Patient Responsible party

Responsible Party Name:____
Address:____________________________________ City: _________________
State:__________ Zip:_______________ Phone #:_______________________

Listed below are individuals that may receive medical information as it relates to my care.

Name:_______________________________ Relationship:_________________

Name:_______________________________ Relationship:_________________

Name:_______________________________ Relationship:_________________

SIGNATURE:___________________________________ Date:_____________

Witness if Needed:_______________________________ Date:_____________