The Cypress Clinic
Maureen Lannan, MD
Kenneth Thomas, MD
Rebecca Braud, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, _____, have received and
Patient Name **Date of Birth**

read the Notice of Privacy Practices Version 001 for the physicians listed above.

_____ _____
Signature of Patient **Date**

_____ _____
Guarantor if Patient is a Minor **Relationship**

I hereby authorize the physicians listed above to disclose any information from my health records to the following individuals: (THIS INCLUDES: Spouse, Children, Etc.)

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

_____ _____
Date **Signature of Patient**

_____
Signature of Witness