Penney Weeks DMD 228 Ponte Vedra Pk Dr. #100 Ponte Vedra Beach, FL 32082

904-285-1990

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____ Date _____

Signature

CONFIDENTIALITY

The office of Dr. Penney Weeks & her employees are bound by Florida Statute 395.017 which provides that patient medical records are privileged and confidential and may not be disclosed without the consent of the patient. No patient information shall be given to anyone telephoning or inquiring about a patient or former patient, including spouses, family members, relatives, employers, former patients, unless a valid patient consent has been obtained.

_____ No, I do not consent to release the information in my medical record

_____Yes, I hereby consent to release any and all information from my medical record to:

Name	Relationship
_____	_____
_____	_____
_____	_____