Name: ______________________
DOB: ______________

Acknowledgment of Receipt of
Notice of Privacy Practices and information release form

Marc Webb, MD, FACS

I authorize Dr. Webb and representatives to communicate information about my care to: ***(please initial)***

Family members: Yes _______ No _______

My other doctors: Yes _______ No _______

My dialysis unit: Yes _______ No _______

List family members: _______________________________________

____

I authorize the access of my RX history. Yes ______ No ______

I authorize the use of images of my graft or fistula for educational purposes

Yes _______ No _____

I acknowledge receiving a Notice of Privacy Practices. (Date:____________)

Signature of patient or authorized representative ___________________

Printed name of authorized representative (if applicable) __________________

Patient email address: ___________________________________