



By signing below, I hereby acknowledge receipt of the following:

"Notice of Privacy Practices" (effective 4/14/03)

The attached notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information. Please review it carefully. If you have any questions, please contact the number at the end of Privacy Practice notice attached.

Please list name and relation of person that may be able to access any information on your behalf.

Name	Relation	Phone number
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"Office Policy" for the Office of Patrick A. Meere, MD PC

Attached is the acknowledgement of the "Office Policy" of Patrick A. Meere, MD., P.C. (the "Practice").

"I acknowledge that this signature serves as a release of medical records to me and/or any other parties that I request. Companies that may require medical records may also have access as long as they provide a release on my behalf."

"I acknowledge the practice will use and disclose my health information for the purpose of treating me, obtaining payment for services rendered to me, and conduct healthcare operations."

Last Name	MI	First Name
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Signature