David B. Schwartz, M.D., LLC

2055 Reading Rd #120

Cincinnati, OH 45202

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, ______________________________________, acknowledge that HIPAA means we will not release any of your information without your written consent. A copy of Dr. Schwartz's Notice of Privacy Practices is available at your request.

________ Request a copy of HIPAA Policy ________ Decline a copy of HIPPA Policy

I, ______________________________________, authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and appeals on my behalf. I understand that billing is done by a third-party and that I may contact them with questions regarding my account at 513-843-7716 Opt #1.

MEDICAL RECORDS INFORMATION RELEASE

I, ______________________________________, in the event of an emergency, I authorize the release of all necessary medical information to:

__________________________________ _________________ ____________________________

Name Phone Relationship

__________________________________ _________________ ____________________________

Name Phone Relationship

____ ____________________________

Signature of Patient Date