MEDICAL DIAGNOSTIC ASSOCIATES, P.A.

ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE
AND
DESIGNATION OF DISCLOSURE

Acknowledgment of Privacy Practice Notice

I have received a copy of the Medical Diagnostic Associates Notice of Privacy Practices.

______________________________ ______________
Patient Name Date of Birth

______________________________ ______________
Signature of Patient/Parent/Guardian Date

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Medical Diagnostic Associates may disclose my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Medical Diagnostic Associates will disclose only information that is directly relevant to the
person's involvement with my health care or payment relating to my health care.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Medical Diagnostic Associates' making the limited disclosure described above. I understand that I am not required to list anyone. I also understand that I may change this list in writing at any time.

______________________________ Date of Birth: ____________
Print Name

______________________________ Date of Birth: ____________
Print Name

______________________________ Date of Birth: ____________
Print Name

______________________________ Date: ____________
Signature of Patient/Parent/Guardian