Paul T. Stallman, MD, Inc.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have read/received a copy of Paul T. Stallman, MD, Inc.'s
Patient Name

Notice of Privacy Practices. (Please ask to review a copy upon check-in)

_____ _____
Signature of Patient Date

I, _____ consent the office of Dr. Paul T. Stallman to release
Patient Name

information about my medical condition and/or treatment to: _____
Relative/s Name/s

_____.
Phone

I authorize for this person to schedule appointment/surgeries on my behalf until:

☐ _____ ☐ The end of my treatment ☐ indefinitely
Date

_____ _____
Signature of Patient Date