**HIPAA Notice of Privacy Practices**

Edward J. Domanskis, M.D., Inc.
Rachelle Gallardo-Privacy Officer
(949) 640-6324

I hereby acknowledge that a copy of this medical practice's Notice of Privacy Practices, has been available to me for review. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

□ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:_____.
Signed:
_____Date:_____
Print Name:
_____Telephone:_____
If not signed by the patient, please indicate relationship:
□ parent or guardian of minor patient
□ guardian or conservator of an incompetent patient
Name and Address of Patient:
_____
_____
_____

**HIPAA Notice of Privacy Practices – Information**

Name of Patient:
_____
Address:
_____
_____

*For Office Use Only:*
*Complete the following only if the Patient refuses to sign the Acknowledgment:*
Efforts to obtain:
_____
_____
Reasons for refusal:
_____
_____