



131 Webb Drive, Suite C
Davenport, FL. 33837

Privacy Practices Notice Acknowledgment

I, _____ (please print name),

have read the **REQUIRED HIPPA NOTICE** of Cypress Medical Center a.k.a. Dr. Raphael Lopez, LLC, Patient Privacy Practices which described how my private medical information may, by law or personal intent, be used and disclosed and I understand how I can get access to my medical information and where to seek redress for grievances. By signing, I acknowledge receiving a copy of the Privacy Practices Notice issued by Dr. Raphael Lopez and consent to these Privacy Practices.

Signature _____ Date _____