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 _____