SEAN A. SIMON, M.D.

3850 Bird Road - Suite 201. Miami, FL 33146
305-668-0496

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES
AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I was provided with a copy of the Sean A. Simon. M.D. Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Sean A. Simon, M.D. continues in its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purpose and the activities permitted under the federal privacy law, which are described in the Notice of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (305) 668-0496 or by requesting one at the office of Sean A. Simon, M.D.

_____ _____

Patient Name | Date

_____ _____

Signature of Patient or Personal Representative | If personal representative, personal representative's relationship to patient

If you received this form electronically, please sign and date the form and return it to the office of Sean A. Simon, M.D. at 3850 Bird Road - Suite 201 Miami, FL 33146 or fax it to (305) 667-7459.

For Physician Office's use only:

Complete this section of the form if not signed and dated by the patient or patient's representative.

Patient Name: _____ Date of Birth: _____

SS# _____ Phone Number: (____) _____

Address: _____ Date signature requested: _____

Reason that the signature and date not obtained: _____