

By signing below, I state that I have been given my own copy of the John A. Martin Primary Health Care Center's Notice of Privacy Practices, effective 09/23/13.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**OR**

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Signature of Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Authority to Act on  
Behalf of Patient