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PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practice and I have been provided an opportunity to review it.

NAME (Print): _____

SIGNATURE (Parent's if under 18): _____

Date of birth : _____ Today's Date: _____

To Whom May We Release your Medical Information?

Spouse: Yes / No Phone #: _____

Parents: Yes / No Phone #: _____

Children: Yes / No Name: _____
Phone #: _____

Name: _____
Phone #: _____

Siblings: Yes / No Name: _____
Phone #: _____

Name: _____
Phone #: _____

Primary Care Physician: Name: _____
Phone#: _____

Other: Yes / No Name: _____
Phone #: _____