Patient Name: _____

DOB: ___/___/_____ Medical Record #: _____

I have been provided with a copy of Southern Tier Arthritis and Rheumatism's Notice of Privacy Practices.

Patient Signature: _____ Date: ___/___/_____

Or

Signature of personal representative _____

Relationship to patient: _____ Date: ___/___/_____

If signature not obtained, please indicate reason:

- X Patient declined
- X Emergency signature
- X Other _____

Staff Member's Name (please print): _____

Date: ___/___/_____