PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

I understand that as part of my healthcare, GENE E. WYLL, M.D., P.A. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Gene E. Wyll, M.D, P.A.'s *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that Gene E. Wyll, M.D., P.A. reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice of Privacy Practices* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and Gene E. Wyll, M.D., P.A. is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Gene E. Wyll, M.D., P.A. has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

□ I request the additional people/agencies have access to the use and/or disclosure of my personal health information: _____
_____
_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed Gene E. Wyll, M.D., P.A.'s *Notice of Privacy Practices* dated April 14, 2003. Check One: _____ I have returned the Notice of Privacy Practices to the front office or _____ I have elected to keep the copy of the Notice of Privacy Practices.

_____	_____
Date of Patient Signature	Date & Time of Witness Signature
_____	_____
Signature of Patient or Legal Representative	Witness Signature
_____	_____
Print Name of Patient or Legal Representative	Print Name of Witness

I request that changes to the *Notice of Privacy Practices* be sent to me at this address:

_____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.