

**DIABETES, THYROID AND ENDOCRINOLOGY OF NORTHERN OHIO**

**ACKNOWLEDGEMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

I understand that Diabetes, Thyroid and Endocrinology of Northern Ohio may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Diabetes, Thyroid and Endocrinology have the right to change this notice at any time. I may obtain a current copy by contacting the doctor's office.

My signature below constitutes my acknowledgement that I have been provided with a copy of the "Notice of Privacy Practices".

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient