RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, ___________________________________ have read a copy of the ______________________________
(MSM Office Location)

(Patient Name) ____

Notice of Patient Privacy Practices.

Signature of Patient ____

Date ____

Parent or Legal Guardian ____

OUR OFFICE LOCATIONS

7th Ave Physical Medicine
& Rehabilitation
512 7th Avenue, 14th Floor
New York, NY 10018
212.768.7979

Downtown Physical Medicine
& Rehabilitation
30 Broad Street, 20th Floor
New York, NY 10004
212.792.9292

Westside Physical Medicine
& Rehabilitation
244 West 54th Street, 3rd Floor
New York, NY 10019
212.262.7246