

KAGAN, JUGAN & ASSOCIATES, P.A.

**PATIENT'S ACKNOWLEDGMENT OF RECEIPT OF
MEDICAL INFORMATION PRIVACY NOTICE**

I hereby acknowledge that I received the Kagan, Jugan & Associates, P.A. Medical Information Privacy Notice for my review prior to receiving services through Kagan, Jugan & Associates, P.A.

Signature of Witness (if patient signs with an "X")

Print Name of Witness

Signature of Patient or Patient's Representative

Print Name of Patient or Patient's Representative

Relationship of Patient's Representative to Patient

Date