



## PATIENT ACKNOWLEDGMENT AND CONSENT

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I have been given a copy of Dr. Arun K Gupta, PC's Notice of Privacy Practices, version effective **Jan 1, 2015**. I consent to the uses and disclosures of my health information as outlined in the Notice.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: \_\_\_\_\_

\_\_\_\_\_

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