

## ACKNOWLEDGEMENT

I acknowledge that I have read and understand Dalius Kedainis, M.D., Notice of Privacy Practices and consent to the use or disclosure of my protected health information by Dalius Kedainis, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Dalius Kedainis, M.D. and as required by law.

I also acknowledge that I understand my rights as a patient of this practice concerning my Protected Health Information, as it is outlined in this notice. I am aware Dalius Kedainis, M.D reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

---

Name of Patient or Personal Representative

---

Signature of Patient or Personal Representative

---

Date

---

Description of Personal Representative's Authority

This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state laws where that state law is more stringent than the federal law or other state law exceptions apply.