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Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Dr. Dustin Bernard's Notice of Privacy/Office Policies, detailing how my information may be used and disclosed as permitted under Federal and State law. I understand the contents of the notice and I request the following restrictions concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

Signed _____ Dated _____

If not signed by patient, please indicate relationship to patient (e.g., spouse).

Relationship _____ Witnessed By _____