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Acknowledgment of Receipt of Privacy Notice
Original to be maintained in patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian,
personal representative, etc.)

Original Effective Date: December 1, 2003

Effective Date of Last Revision (if any): _____