Stoneybrook Family Medicine
16106 Marsh Road, Suite 102
Winter Garden, FL 34787
p 407.347.0600
f 407.347.0599

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, have received a copy of Orlando Health's Notice of Privacy
(patient name)

Practices.

_____ _____

Signature **Date**

I authorize Stoneybrook Family Medicine to discuss my treatment and release my Personal Health Information (PHI) to the following people:

_____

_____

_____

_____

I understand that I may revoke this authorization at any time by notifying Stoneybrook Family Medicine's

office at 16106 Marsh Road, Ste. 102, Winter Garden FL 34787.

_____ _____

Signature of patient **Date**