David Herson MD PA
21756 State Road 54
Suite 102A
Lutz, FL 33549

Acknowledgement of Receipt

OF NOTICE OF PRICACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

_____

Signature of Patient or Authorized Personal Representative

_____

Print Name of Patient or Authorized Personal Representative

_____ _____

Date

Description of Personal Representative's Authority (e.g.., parent or legal guardian)