AUSTIN PODIATRY, PA
MARK S. ROBSON, D.P.M.
MICHAEL H. GOLF, D.P.M.
CK DAVID LIOU, D.P.M.

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have the opportunity to request and receive a copy of this office's Notice of Privacy Practices, which explains how my medical and billing information will be used and disclosed.

Patient Name (please print) Date

Parent or Authorized Representative (if applicable)

Signature

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