



## **NOTICE OF PRIVACY PRACTICE**

By signing this document, I acknowledge that a copy of the BroMenn Physicians Management Corporation's Notice of Privacy Practices has been made available to me. I understand that I may request to receive a copy of the notice at any time. The Privacy Notice can also be found on the BroMenn Healthcare website at [www.bromenn.org](http://www.bromenn.org).

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**Please Print Patient's Name**

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**Signature of Patient or Legal Guardian if patient is a minor or unable to sign**

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**If someone other than the patient signed, please indicate relationship to patient**

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**Date of Signature**