Albert T. Domingo MS, MD Inc.
3120 Parkway St. NW Suite A
Canton, Ohio 44708

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Albert T. Domingo, MS, MD Inc.'s operations. The notice of Privacy Practices also describes my rights and Albert T. Domingo MS, MD Inc.'s duties with respect to my protected health information. The Notice of Privacy Practices is posted in our waiting room.

Albert T. Domingo MS, MD Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail, or asking for one at time of appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority