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**PRIVACY POLICY ACKNOWLEDGEMENT**

**I acknowledge that I have read and understand the Notice of Privacy Policy for the  
above named practitioners.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

**Please indicate the numbers in which we are able to leave a message with medical  
information:**

**Home #** \_\_\_\_\_  
**Cell #** \_\_\_\_\_  
**Work #** \_\_\_\_\_

**I give my permission for the above named practitioners and the office staff to  
discuss any of my medical information with:**

**(Other than Physicians or your Insurance Company)**

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone** \_\_\_\_\_

**I understand that I must provide a written change to the office of the above named  
practitioners to change/delete this information.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**