Dunkirk Family Practice
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NOTICE OF HEALTH INFORMATION PRACTICES

This notice will expire in twenty (20) years.

DUNKIRK FAMILY PRACTICE, P.A. has provided me with the information concerning my health information and how it is or can be used. I have read the Notice of Health Information Practices and understand that a copy is available upon my request.

☐ By checking this box, I am opting out of receiving fundraising communications with Dunkirk Family Practice, PA. I am aware that by checking this box, Dunkirk Family Practice acknowledges my right to opt out and will not send fundraising communications to me as of this date.

_____
Print Name

_____
Patient Signature (Parent of Minor)

_____
Date of Birth

_____
Name of Minor Child

_____
Date