SANTÉ
CARE CENTER

AFFILIATED WITH SANTÉ PHYSICIANS
A MEMBER OF SANTÉ FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION

NOTICE OF PRIVACY PRACTICES
CONSENT FORM

By my signature below, I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Santé Care Center.

_____
Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority