

**Acknowledgement of Review of
Notice of Privacy Practices
iMED Internal Medicine**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I have been advised that iMED often participates in clinical research trials which may be of benefit to specific patients. I hereby agree that I may be contacted by the clinic staff if I am eligible for possible participation.

In addition, I give permission for you to share my information with the following individuals.

Signature of Patient or Personal Representative

Printed Name of Patient

Date

Relationship if Representative