



**BANDER FAMILY MEDICAL CLINIC  
STEVEN G. BANDER, D.O.,P.A.**

Receipt of Notice of Privacy Practices  
Written Acknowledgement Form

I, \_\_\_\_\_, have had the opportunity to review the  
Patient name

Privacy Practices of Steven G. Bander,D.O.,P.A. and Bander Family Medical Clinic. I have been given the abbreviated version of the policy, and have/have not requested a copy of the complete policy.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Witness



## Bander Family Medical Release of Information to Family Member

Bander Family Medical has my permission to talk to the following family members about my condition, medications, and treatment. This permission may be revoked by me at any time, but I agree to give notice prior to information being released. I will not hold Bander Family Medical, or Dr. Bander and his staff, responsible for releasing information, which was given in good faith while this release was in effect.

Name	Relationship	Phone
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Name	Relationship	Phone
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\_\_\_\_\_  
Patient or Guardian

\_\_\_\_\_  
Date