Notice of Privacy Practices / Aviso de Prácticas de Privacidad

I am signing in consent that as of today I received the Notice of Privacy Practices of Progressive Medical Center. I understand I have a right to review this Notice of Privacy Practices prior to signing this document.

_____

Date

_____ _____

Name of patient or personal representative Signature of patient or personal representative

Firmo el consentimiento de que hoy recibí el aviso de prácticas de privacidad de Progressive Medical Center. Entiendo que tengo el derecho de revisar el aviso de prácticas de privacidad que me han otorgado antes de firmar este documento.

_____

Date

_____ _____

Name of patient or personal representative Signature of patient or personal representative