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Good Medicine Takes Time

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Thomas Susko, M.D., Inc., healthcare operations. The Notice of Privacy Practices also describes my rights and Thomas Susko, M.D., Inc.'s duties with respect to my protected health information. The Notice of Privacy Practices is posted in our office.

Thomas Susko, M.D., Inc., reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of next appointment.

Date: _____

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Relationship to Patient