

**Judith L. Thompson, M.D., P. A.**  
**Privacy Practices Acknowledgement**

I have been informed of the Privacy Practice of Judith L. Thompson, M.D., P.A. and have been given the opportunity to review it. I understand that I may obtain a copy of the Privacy Practice at my request.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

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