

Tree of Life Wellness  
Dr. Cheryl Sly

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, acknowledge that I have received a copy of Tree of Life Wellness Notice of Privacy Practices.

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Patient or legally authorized individual signature

Date

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Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal Representative, etc.)

I authorize and agree that Tree of Life Wellness may disclose my protected health information to the following persons, each of who is directly involved in my care:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

I acknowledge and agree that Tree of Life Wellness may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to Tree of Life Wellness.

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Patient or legally authorized individual signature

Date

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Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal Representative, etc.)

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):

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