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**ACKNOWLEDGMENT OF NOTICE**

I acknowledge receipt of Dr. Gotchel's Notice of Privacy Practices and agree to the above practice. I also give permission to leave messages on my answering machine or with family members. I also hereby request that other providers release information on my diagnosis, treatment, prognosis, and other data as Dr. Gotchel deems potentially pertinent to my treatment.

In addition to me, you may discuss my care, test results, and billing issues with the following members or friends.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship and Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship and Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship and Phone Number

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient (Print)