EASTERN SCHOOL
OF ACUPUNCTURE AND TRADITIONAL MEDICINE

PATIENT PRIVACY POLICY

INTERN CLINIC PATIENT FORM

First Name _____ **Last Name** _____

Phone _____ **Email** _____

PRIVACY POLICY UNDERSTANDING
I have read and understood the notice of privacy policies of the intern clinic at the Eastern School of Acupuncture and Traditional Medicine.

Patient or Representative

Sign here

Relationship to the Patient

Date

Eastern School of Acupuncture Staff Member

Sign here

Print Name

Date