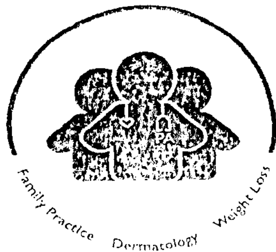

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

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Name of Patient   Date of Birth

____

Signature of patient or personal representative

____

If signed by personal representative, relationship to patient

____

Date