Acknowledge of Receipt of Notice of Privacy Practices

I have received this office's Notice of Privacy Practice, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Patient's Representative

_____

Date

This form is to be place in the Patient's medical file. This form is to be retained for a minimum of six years. **Should the Patient choose not to sign this form**, please comment below as to why the Patient did not sign and then place this form in the Patient's medical file.

Comments (if Applicable):

Form received by:

_____

Name Date