Acknowledgement of Receipt of Privacy Practices

Name of Patient: ____

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _______________________________ Date: _________________

Print Name: ____________________________ Phone: _______________

If signed by a guardian, please indicate the relationship to patient:

____

For Office Use Only:

Signed form received by: ____

Acknowledgement Refused: ______________________________________