ACKNOWLEDGEMENT OF RECEIPT OF NOTICE 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 guardian, please indicate relationship to patient:
_____

For Office Use Only:
Signed form received by: _____
Acknowledgement Refused:_____

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