

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE 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: _____

Printed Name: _____

Phone: _____

If signed by guardian, please indicate relationship to patient: _____

For Office Use Only:

Acknowledgement Received By: _____

Acknowledgement Refused: _____