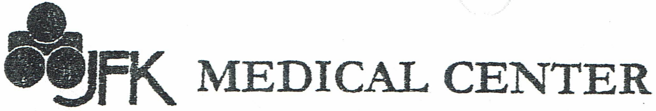

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

A Notice of Privacy Practices is provided to all patients. The NPP identifies how medical information about you may be used or disclosed.

By signing below I hereby acknowledge receipt of the Notice of Privacy Practices.

Patient ____
(PLEASE PRINT)

Patient Signature ______________________________________

Patient Personal Representative __________________________

Relationship ____

Date ____

CARBON COPY TO PATIENT

ORGINAL TO MEDICAL RECORDS