ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your protected health information. Please sign this form to acknowledge receipt of this Notice. You may refuse to sign this acknowledgement, if you wish.

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I acknowledge that I have received a copy of this Office's Notice of Privacy Practices.

_____ _____ _____

[Please Print your Name Here] Signature Date Signed

NOTE: PATIENT REFUSED TO SIGN FORM:_____

Staff Member Signature & Date Refused