

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient
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Name of Patient: \_\_\_\_\_

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**For Office Use Only:**

Signed form received by: \_\_\_\_\_

Efforts to obtain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_