

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be posted in the physician's office or will be made available to me at my request.

Signed: _____

Date: _____ Patient's D.O.B.: _____

If you are not the patient, please specify your relationship to the patient _____.