ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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I hereby acknowledge that I received a copy of these medical practices **Notice of Privacy Practices**. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

□ I would like to receive a copy of any amended Notice of Privacy by e-mail at ______________________

Signed: ______________________________ **Date:** ________________

Print Name: ___________________________ **Telephone:** _____________

If signed by other than patient, please indicate relationship:

- □ Parent or guardian of minor
- □ Guardian or conservator of incompetent patient
- □ Beneficiary or representative of deceased patient

Name of Patient: ____

9/17/2008