ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

Signature: _____

****If Signature is not the patient, please indicate the relationship of person signing for the patient. (e.g., Parent, Family Member, Spouse, Guardian, Close relative or Guarantor):**

_____ _____
(Print last, First Name) Relationship

If Patient or Patient's personal representative does not sign, indicate the reasons why signature could not be obtained.

_____

Office Use Only

_____ Date: _____
Name of Practice Staff Member