Privacy Practices Acknowledgement

I have read the Notice of Privacy Practices and I have been provided an opportunity to review the information and ask any questions. I also understand that a copy of the Notice of Privacy Practices will be provided to me, for my records, upon my request.

Patient's Name: ____Date of Birth:________
(please print)

Signature: _____________________________________Date: ______________________

Relationship to patient: ____self ____spouse ____parent ____other. *Print your name below if you are not the patient.*

Name: ____

Copy of Privacy Practices given to patient by ____________initials ___________date