

## **Acknowledgement Receipt of Notice of Privacy Practices**

I hereby acknowledge that I received a copy of this medical practice's Notice of 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 Practice's at each appointment.

I would like to receive a copy of any amended Notice of Privacy practice

by e-mail at: \_\_\_\_\_ .

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Name and Address of Patient: \_\_\_\_\_

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