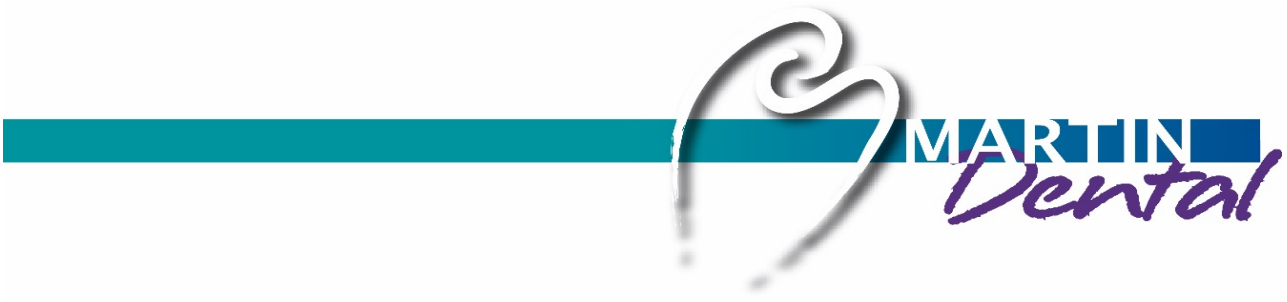

Would you like a copy of the Privacy Practices Notice? ____ YES ____ NO

SECTION A: The Patient.

Name:_____

Address:_____

Telephone:_____ E-mail:_____

Patient Number:_____ Social Security Number:_____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I,_____ acknowledge that I am able to receive a Notice of Privacy Practices from the above named practice if I so choose.

Signature:_____ Date:_____
If a personal representative signs this authorization on behalf of the individual, complete the following:

Relationship to the patient if you are not the patient: _____

SIGNATURE.
I attest that the above information is correct.

Signature:_____ Date:_____

Print Name:_____ Title:_____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE