



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