NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment of Receipt

[Patient May Refuse To Sign this Agreement]

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(name of healthcare practice or doctor's name)

This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgement:
<u>You are only confirming that you have received a copy of our PRIVACY PRACTICES</u>.

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I have received a copy of this office's Notice of Privacy Practices:

Print your name here: ______________________________________

Sign your name here: ______________________________________

Fill in today's date here: ____________________________________

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This form does not constitute legal advice. Practices are encouraged to discuss legal issues and concerns with their attorney to assure applicability.