

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

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
- \_\_\_\_\_ Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

---

For Office Use Only:

\_\_\_\_\_ Signed form received by: \_\_\_\_\_

\_\_\_\_\_ Acknowledgement refused:

Efforts to obtain: \_\_\_\_\_

\_\_\_\_\_

Reasons for refusal: \_\_\_\_\_

\_\_\_\_\_