



NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment of Receipt

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 Acknowledgment:

You are only confirming that you have been offered a copy of our Privacy Practices.

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 been offered a copy of this Office's Notice of Privacy Practices:

Print Patient Name: _____

Sign your name: _____

Date: _____