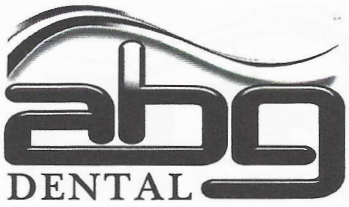


# ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Patient Name:_____ DOB:_____ SS#:_____

Address:_____ Zip Code:_____

Telephone:_____ Cell#:_____

Emergency Contact Name:_____ Phone#:_____

**Acknowledgement of Receipt of Privacy Practices Notice.**

I, _____, acknowledge that I have received a notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

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

Personal Representative's name: _____

Relationship to individual: _____

**OFFICE USE ONLY**

**Good Faith Effort to Obtain Acknowledgement of Receipt.**

O Individual refusal to sign

O Other _____

**STAFF SIGNATURE:**

Signature:_____ Date: _____

Print Name:_____ Title:_____