

# Acknowledgment of Receipt of Privacy Notice

(Original to be maintained in Patient's permanent medical record)

I acknowledge that I have received a copy or have read the office's Notice of Privacy Practices.

\_\_\_\_\_  
Patient of legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Relationship  
(parent, legal guardian, personal representative, etc)