



## Acknowledgement of Receipt of Notice of Privacy Practices

(Required by HIPAA, the Health Insurance Portability and Accountability Act)

**Patient** \_\_\_\_\_ **Date of birth** \_\_\_\_\_

I acknowledge that I have received a copy of Notice of Privacy Practices for Protected Health Information with the effective date of December 1, 2010.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

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

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