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Acknowledgement of Receipt of Notice of Privacy Practices

**Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish..**

I acknowledge that I have received a copy of this office’s Notice of Privacy Practices

 Patient Name DOB Today's Date

 Patient Signature