

## Receipt of Notice of Privacy Practices Form

I, \_\_\_\_\_, hereby acknowledge receipt of the  
(Patient's Name)  
physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient:

\_\_\_\_\_