ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I, _____[print name], understand that as part of my healthcare, this facility maintains health records describing my health history, symptoms, test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices which provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Privacy Practices and prior to implementation of the changes, I will receive a revised notice to the address I provided.

PATIENT NAME: _____

DATE OF BIRTH: _____ PHONE: _____

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____

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