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Notice of Privacy Practices Acknowledgement Form

**THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:**

- **How this office will use and disclose your protected health information.**
- **Your privacy rights with regard to your protected health information.**
- **This office’s obligations concerning the use and disclosure of your protected health information.**

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

\_\_\_\_\_  
Patient or Patient Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Patient Representative Printed Name