AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that have read or have had the opportunity to read it, if I so chose, and understand the Notice.

_____

Patient Name (please print) Date

_____

Parent or Authorized Representative

_____

Signature

Please add anyone who may access your chart or call the office in your behalf below:

Name:_____Relation:_____Phone:_____
Name:_____Relation:_____Phone:_____
Name:_____Relation:_____Phone:_____