

**ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Patient Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (“PHI”) about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

Name of Patient

Signature of Patient

Date:_____