



Acknowledgement of Receipt of Notice

I hereby acknowledge that I have read this medical practices notice of Privacy Practices.

Yes ____ No ____ I wish to receive a copy of Notice of Privacy Practices.

Signed _____ Date _____

Name: Robert L. Smith Telephone : (333) 444-5555

If not signed by the patient indicate relationship

- Parent or guardian if patient is a minor
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient (if different than above) _____

For office use only:

Signed and received by: _____

Acknowledgment refused: _____

Efforts to obtain

Reasons for refusal

