

Acknowledgement of Review of Notice of Privacy Practices

| I have reviewed the office's Notice Of Privacy Practice, which explains how my medical information will be used and | |
|---|------------------|
| disclosed. I understand that I am entitled to receive a copy of | f this document. |
| Signature of Patient or Personal Representative | |
| Date | |
| Name of Patient or Personal Representative | |
| Description of Personal Representative's Authority | |