

## Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Printed Name of Patient or Personal Representative      Date

\_\_\_\_\_  
Signature of Patient or Personal Representative      Date

\_\_\_\_\_  
Description of Personal Representative's Authority      Date