ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, acknowledge
(insert name of patient)

receipt of a copy of Provider's **NOTICE OF PRIVACY PRACTICES**.

Date: _____

Patient or Legal Guardian Signature:_____

Legal Guardian Name:_____

Received by:

_____
(Print Name of Staff Member)

_____
(Signature of Staff Member)

*****This completed form must be scanned into the patient's EMR*****