



## Receipt of Notice of Privacy Practices

I, \_\_\_\_\_ (print name)  
acknowledge receipt of a copy of the Company's **NOTICE OF PRIVACY PRACTICES**.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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