Notice of Privacy Practices Written Acknowledgement

Name: _____

Patient ID: _____ DOB: _____

I acknowledge that I have had the opportunity to receive a notice of privacy practices, which describes how my medical information may be used and disclosed and how I can get access to this information. I understand that I am entitled to a copy of this authorization.

Reason for patient's inability to sign, if applicable:_____

Relationship to the patient:_____

Signature: _____ Date:_____