**NOTICE OF PRIVACY PRACTICES**

***PATIENT ACKNOWLEDGEMENT***

Name: ____________________________________________

Address: __________________________________________

City, State ZIP: _____________________________________

Phone: ____________________________________________

I hereby acknowledge that I have received a copy of the organization's Notice of Privacy Practices.

| Patient Name: | Patient Date of Birth: | Patient Social Security #: |
|---|---|---|
| | | |

______________________________
Signature of Patient/Representative

______________________________
Relationship of Representative

______________________________
Date

Other persons authorized to receive information about this patient are:

| Name | Relationship |
|---|---|
| ____________________________ | ________________________ |
| ____________________________ | ________________________ |
| ____________________________ | ________________________ |