# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Full Name: ______________________________________________________________
(Please Print)

I acknowledge that I have read and understand this Notice of Privacy Practices.

Signature:____________________________________________ Date: __________________
(Patient / Personal Representative)

If a Personal Representative's signature appears above, please describe the relationship between the patient and Personal Representative: __________________________________

Is there a friend or family member to whom you wish to allow access to your health care information? _______ Yes _________ No

If you answered YES to the above, please complete the following:

I __________________________________, give permission to the following friends or family member(s) to have access to my health care information:

1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________
5. ___________________________________

Signature:____________________________________________ Date: __________________
(Patient / Personal Representative)