

# Acknowledgement of Privacy Practices

My signature below confirms that I have received my health care practitioner's Notice of Privacy Practices. I have reviewed this Notice and agree to its terms.

I acknowledge that this office reserves the right to change the terms of the Notice of Privacy Practices and revisions will be posted on the effective date. I may also contact this office at the address below to obtain a current copy.

I have read and understand this acknowledgement.

Printed Name: \_\_\_\_\_

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