

**Acknowledgement of Receipt of Notice of Privacy Practices**

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

\_\_\_\_\_  
Patient's Name (print)

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

\_\_\_\_\_  
Date