



**ACKNOWLEDGMENT AND REVIEW OF NOTICE OF PRIVACY PRACTICES**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I agree to the terms listed as proper security and privacy of my protected health information. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Signature of Patient / authorized representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date