



RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

Printed name of patient

Patient medical record # and/or DOB

- I have received a copy of the Notice of Privacy Practices.
- I was offered a copy of the Notice of Privacy Practices but declined to take a copy.
- I wish to share my medical information with _____

Print name/ relationship

Signature of Patient: _____

Date: _____

Signature of Guardian: _____

Date: _____