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Clinic Director
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ACKNOWLEDGEMENT OF RECEIPT AND OR OPTION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I:

☐ Was provided a copy of the Notice of Privacy Practices

☐ Was provided a copy of the Notice of Privacy Practices and decline

and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____
Patient Name (Please print)

_____ _____
Signature Date

_____
Parent, Guardian or Patient's legal representative
(Please print)

_____ _____
Signature Date

_____ _____
Witness Date

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.