

# ACKNOWLEDGEMENT OF RECEIPT

OF

# NOTICE OF PRIVACY PRACTICES

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.**

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature

## Addendum

I hereby authorize the following family member, relative or designated representative access to protected health and/or billing information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_ Protected Health Information

\_\_\_ Billing Information