

**Receipt of Notice of  
Privacy Practices Form**

I, \_\_\_\_\_, hereby acknowledge receipt of the physician's Notice of  
(Patient's Name)  
Privacy Practices. The Notice of Privacy Practice provides detailed information about  
how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices  
that are described in the Notice. I also understand that a copy of any Revised Notice will  
be provided to me or made available.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient \_\_\_\_\_.

-Patient's file