## ACKNOWLEDGMENT 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 understood the Notice.

		,
Patient Name (please print)	Date	
	- 1	
Parent or Authorized Representative (if applicable)		
	7.0	
Signature		