NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and to copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so.

Our **Notice of Privacy Practices** describes in detail how your health information may be used and disclosed, and how to access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, etc.)

(Notation, if any, by staff)

This form will be retained in your medical record.