Acknowledgement of Receipt
Notice of Privacy Practices

By signing below I acknowledge that I have read and received the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. **By Signing below I consent for the use of my personal health information of treatment, payment, and operations and other uses as described in the privacy notice.** I also understand that I have the right not to sign this agreement.

Name: ____
(please print)

Signature: ______________________________________
(Patient, parent or legal guardian)

Relationship to patient: _____________________________

Date: _______________________