ACKNOWLEDGMENT FORM

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THIS FORM IS USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

NAME OF PATIENT (PLEASE PRINT)	
OLOMATURE OF RATIENT	DATE
SIGNATURE OF PATIENT	DAIL
YOU MAY REFUSE TO SIGN	THIS ACKNOWLEDGMENT
BELOW THIS LINE IS FO	OR OFFICE USE ONLY
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PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY	
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ITLE	DATE