



**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

I, _____, acknowledge
(insert name of patient)

receipt of a copy of Provider's **NOTICE OF PRIVACY PRACTICES**.

Date: _____

Patient or Legal Guardian Signature: _____

Legal Guardian Name: _____

Received by:

(Print Name of Staff Member)

(Signature of Staff Member)

*****This completed form must be scanned into the patient's EMR*****