Family Practice Physicians

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been provided a copy of the Family Practice Physician's (FPP) Privacy Notice that describes how my health information is used and shared. I understand that FPP has the right to change this notice at any time. I may obtain a current copy by contacting FPP.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

X _____ X _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

If signature not obtained, reason why? _____
(e.g. patient refused, etc)

Signature of FPP employee/Witness: _____