# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

We keep a record of the health care services we provide you. You may ask to see and 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. You may see your record or get more information about it by contacting our Administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can 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, personal representative)

Any Staff Notation:

This form will be retained in your medical record.

Last update ___/___/___