ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

I am required to advise you of my Notice of Privacy Practices, which states how I may use and/or disclose your health information. A copy will be provided upon request.

I acknowledge that I have been made aware of this office's Notice of Privacy Practices. I may refuse to sign this acknowledgement, if I wish.

_____

Patient's name *Patient's Date of Birth*

_____

Please print your name here (if different from above) *Relationship to Patient*

_____

Signature

_____

Date

_____

FOR OFFICE USE ONLY

I have made every effort to obtain written acknowledgment of receipt of my Notice of Privacy from this patient, but it could not be obtained because:

[ ] The patient refused to sign.

[ ] Due to an emergency situation, it was not possible to obtain an acknowledgement.

[ ] I wasn't able to communicate with the patient.

[ ] Other *(Please provide specific details)*

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_____ _____

Eugene F. Simopoulos, M.D. *Date*