Central Primary Care

ACKNOWLEDGEMENT OF PRIVACY NOTICE

I, _____ , hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy makes available detailed information about how the practice may use and disclose my Privacy Health Information (PHI).

I understand that the physician has reserved the right to amend his or her privacy practices that are described in the notice. I also understand that a copy of any amended notice will be available to me at my request.

Signature:_____

Date:_____

If you are not the patient, please specify your relationship to the patient.

Relationship:_____