

**Acknowledgement of Receipt of Notice of Privacy Practices**

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company’s website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: \_\_\_\_\_  
(print name)

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

or

Patient’s Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_