Acknowledgement of Receipt of Patient Privacy Practices Notice

I have received the *Notice of Patient Privacy Practices for Sheridan Richardson, L.A.c,* which describes how Sheridan Richardson L.A.c may use and disclose my protected health care information to carry out treatment, payment of services, healthcare operations, and other purposes that are allowed by law. This notice also describes my patient rights and Sheridan Richardson's requirements to protect my health information.

Sheridan Richardson, L.A.c reserves the right to change the privacy practices that are described in the *Notice of Patient Privacy Practices for Sheridan Richardson, L.A.c.* All changes will be posted in her clinic. I understand that I may request a copy of this notice at any time and discuss its contents with Sheridan Richardson.

_____ _____

Patient Signature **Date**

_____ _____

Printed Name **Date of Birth**