NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I keep a record of the health care services that I provide to you. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes me to do so.

My ***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.***

_____ _____

Signature of patient Date

This form will be retained in your medical record.

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