

Acknowledgement of Review of Notice  
Of Privacy Practices

I have reviewed the Notice of Privacy Act, which explains how my medical information will be use and disclosed. I understand that I am entitled to receive a copy of this document. Please list any family members you would like to share your medical information with.

X \_\_\_\_\_

Signature of Patient or Representative

X \_\_\_\_\_

Family Member

\_\_\_\_\_

DATE