

## ACKNOWLEDGEMENT AND REVIEW OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I have reviewed this office Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian

\_\_\_\_\_  
Printed name of Guardian

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