



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Practice's Requirements

This Practice:

- A) Is required by law to maintain the privacy of your Private Health Information (hereafter referred to as 'PHI') and to provide you with this Privacy Notice detailing the Practices' legal duties and privacy practices with respect to your PHI.
- B) Under the privacy rule, it may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- C) Is required to abide by the terms of this privacy notice.
- D) Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for your entire PHI that maintains.
- E) Will distribute any revised privacy policy to you prior to implementation.
- F) Will not retaliate against your for filing a complaint.

Effective Date

This notice is in effect as of April 15, 2003.

Patient Acknowledgement

By signing below, I acknowledge receipt of a copy of this Notice.
I have full understanding and am in agreement to its terms.

Patient Name: _____

Patient Signature: _____

Date: _____