ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES



1037 North Flowood Dr Flowood, MS 39232

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed:	Date:
Print Name:	Telephone:
If not signed by the patient, please indic	cate relationship:
Guard	at or guardian of minor patient dian or conservator of an incompetent patient ficiary or personal representative of deceased patient
Name of patient:	
FOR OFFICE USE ONLY:	
Date signed form received by:	
Acknowledgement refused: Efforts to obtain:	