ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Shadow Creek Family Physicians

Patient Name: _____

Date of Birth: _____

I acknowledge that Shadow Creek Family Physicians provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative or Guardian Signature (if applicable) Relationship to Patient