

PATIENT HIPAA ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to its terms.

Name of Patient _____ **Date** _____

Date of Birth _____

**Signature of
Patient/Parent/Guardian** _____