# Notice of Privacy Practices-Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Office Manager.

*By my signature below I acknowledge receipt of the Notice of Privacy Practices.*

______________________________________________

**Patient or Legally Authorized Individual Signature** **Date**

______________________________________________

**Print Patient's Full Name** **Date**

______________________________________________

**Witness Signature** **Date**