



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: \_\_\_\_\_

I have received a copy of the Notice of Privacy Practices. This Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I was given the opportunity to review the Notice and ask questions regarding my privacy rights.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_

Date: \_\_\_\_\_

For ORA Use Only

Received by:

Orthopedic Rehabilitation Associates, PC Agent: \_\_\_\_\_

Date Received: \_\_\_\_\_