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: ____

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