PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

PATIENT NAME: _____ **Date of Birth:** _____

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices of Creekside Medical.

Creekside Medical reserves the right to revise its Notice of Policy Practices at any time. A copy of such revisions is available upon written request.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name Date