

1920 Palm Beach Lakes Blvd., Suite 206 • West Palm Beach, Florida 33409 • 561-207-7702

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices For Protected Health Information, as required by the federal government's HIPAA legislation.

Name of Patient:		
Signature of Patient (or personal represe	ntative of patient)	
Printed name (if different from patient)	Relationship	
 Date		