

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (patient name) acknowledge that I have received a copy of Affiliated Podiatrists, P.C.'s Notice of Privacy Practices. This Notice describes how Affiliated Podiatrists, P.C. May use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

(Signature of Patient, or Personal Representative)

(Date)

(Relationship to Patient)