ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
Internal Medicine for Adults and Adolescents
EFFECTIVE 4/1/2015

I, (patient name)_____acknowledge and agree that I have reviewed a copy of **Internal Medicine for Adults and Adolescents'** Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Date

OFFICE USE ONLY

Internal Medicine for Adults and Adolescents made the following good faith efforts to obtain the above reference individual's written acknowledgement of the Notice of Privacy Practices: (Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons, if known, why the written acknowledgement was not obtained.)

_____

_____

_____

_____ _____
Signature Date

_____ _____
Print Name Date