**NOTICE OF RECEIPT ACKNOWLEDGEMENT**

I, ________________________________________________, acknowledge that I have received Family Health Care Medical Group's Notice of Privacy Practice. I have had the opportunity to read and consider the contents of this Notice of Privacy Practices.

* Patient's signature:___________________________________ * Date:_____________

* Print Patient Name:_______________________________________________________

* Address:_________________________________________________________________

* Home Phone:__________________________ * Cell Phone:_______________________

* Work Phone:__________________________

* DOB:__________________ * Social Security Number:__________________________

*If this authorization is signed by a personal representative on behalf of the individual, complete the following:*

*Personal Representative's Name:*_____________________________________________

*Relationship to Individual:*__________________________________________________