

Better Health, DC, MD.

I, _____ acknowledge that I have received or have
(Please Print Name)
been given the opportunity to receive Notice of Privacy Practices.

Signature: _____

Date: _____

If patient representative signing for patient:

Patient Name: _____

Patient Representative Name: _____

Relationship: _____

Or

Patient or patient representative received or was given the opportunity to receive Notice of Privacy Practices but declined to sign the above acknowledgement.

Name (witness)

Date