ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I acknowledge that I was provided a copy of the *Notice of Privacy Practices* for Dr. Michael Lupovici.

SIGNATURE OF PATIENT **DATE**

PRINT NAME

* If the person signing this is not the patient, please print your name and relationship to the patient.

PRINT NAME

RELATIONSHIP TO PATIENT

I [patient or representative] request a copy of the *Notice of Privacy Practices*: YES☐ NO☐

For Office Use:

If patient/representative requested copy of Notice, date copy was provided _____

If no acknowledgement could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgement: _____

_____

_____