

**NOTICE OF PRIVACY PRACTICES**

**RECEIPT AND ACKNOWLEDGEMENT OF NOTICE**

**PATIENT NAME:** \_\_\_\_\_

**PATIENT DOB:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Dr. Joan Moreau's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Joan Moreau or Della Wright, Office Manager.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent, Guardian or Personal Representative\***

\_\_\_\_\_  
**Date**

\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

\_\_\_\_\_  
**? Patient/Parent/Guardian Refuses to Acknowledge Receipt:**

\_\_\_\_\_  
**Signature of Staff Member**

\_\_\_\_\_  
**Date**