

---

Jefferson

Healthcare Notice of Privacy Practices Acknowledgement

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

Patient Signature: \_\_\_\_\_

Date / Time: \_\_\_\_\_

**If patient is unable to sign:**

Legal Decision Maker Signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship: \_\_\_\_\_