

# NOTICE OF PRIVACY PRACTICES

My signature below indicates that a written copy of the institute's Notice of Privacy Practices was provided to me. I have also been informed that if I require additional information about this notice I may call the Privacy Office.

<b>PATIENT NAME:</b>  
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<b>PATIENT SIGNATURE:</b>  	<b>DATE:</b>  
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<b>Patient Refused to Sign:</b>          <hr/>	
STAFF SIGNATURE	DATE