

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

1. By signing below, I acknowledge that I have received Partners in Internal Medicine's Notice of Privacy Practices ("Notice").

Signature (Patient or Authorized Representative)

Date: _____

Printed (Patient or Authorized Representative)

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2. Patient was unable to sign acknowledgement for one of the following reasons:

Patient Refusal

Patient Disability

Other: _____

Witness

Date