

Drs. Olson & Szakaly
Acknowledgement of Receipt of
Notice of Privacy Practices

****You may refuse to sign this acknowledgement****

Date: _____

I have reviewed this office's Notice of Privacy Practices. (Copies available upon request)

Patient's name: _____

Signature: _____
(Patient, parent or guardian)

Relationship to patient: _____

Please indicate name(s) of person(s) with whom we may share information about your treatment and/or account.

****For Office Use Only****

_____ Acknowledgement was not obtained.
Indicate reason on back of this form.
_____ Employee initials.