Dr. 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.
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____

For Office Use Only

_____Acknowledgement was not obtained.
Indicate reason on back of this form.
_____Employee initials.