RECEIPT OF NOTICE OF PRIVACY PRACTICE FORM

I, _____, hereby acknowledge receipt of NPWH's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how NPWH may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

To be filed on top of the left side of the patient's chart