



Acknowledgment of Receipt of Notice of Privacy Practices

Please Note: Prior to signing this form, make sure you read our HIPPA document available either on our website or in our office.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six (6) years.

Patient's Name (please print)

Date

Parent / Guardian or Patient's Legal Representative

Signature



**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND
MAINTAINED FOR SIX YEARS.**

**1500 MLK Jr. Street North
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