

Acknowledgement of Receipt of Notice of Privacy Practices

Joseph R. Leith, M.D., P.S.C. reserves the right to modify the privacy practices out-lined in the notice. By signing below I acknowledge I have received a copy of the Notice of Privacy Practices for Joseph R. Leith, M.D., P.S.C.

Date _____

Name of Patient _____

Signature of Patient _____

Signature of Patient Representative _____
(Required if the patient is a minor or an adult is unable to sign this form)

Relationship of Patient Representative to Patient _____