

Please Complete Highlighted Blue Section Only

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our *Notice of Privacy Practices*, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (949) 645-2930.

By signing this form, you acknowledge receipt of the *Notice of Privacy Practice* of Robert Skversky, M.D. (Weight No More)

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*)

Employee Signature

Date