

**PRINT AND SIGN THIS FORM**

**PATIENT ACKNOWLEDGEMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICE  
FOR PROTECTED HEALTH INFORMATION**

**DATED:** \_\_\_\_\_

**New York, NY**

**Patient's Name** \_\_\_\_\_

**Signature (Patient or Representative)** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

**Print Name of person signing form (if other than patient)** \_\_\_\_\_