

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ acknowledge that I have received a copy of Dr. Jordan Sheff's Notice of Privacy Practices. The notice describes how Dr. Sheff may use and disclose my protected health information, certain restrictions to the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Relation to Patient