



David V. Spurlin, M.D., PLLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices gives you information about how we use and disclose medical information about you.

By signing this form, you are acknowledging that you received/reviewed a copy of our Notice of Privacy Practices.

Name of Patient: _____

If signed by Patient:

If signed by Personal Representative:

Signature: _____

Signature: _____

Date: _____

Printed Name: _____

Relationship to Patient: _____

Date: _____

.....
For internal office use only:

If not signed, reason:

- Patient refused to sign
- Other _____
- Patient not able to sign (give additional information below regarding disability, emergency situation, etc.)

Comments:

Name of Reviewer

Date