

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

I acknowledge that Apogee Health Promotions provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal Representative Signature (if applicable)

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