Alexander Medical Associates

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HIPAA ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Date of Birth: _____

We at Alexander Medical Associates are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone.

I hereby acknowledge that I have reviewed the HIPPA Notice of Privacy Practice document.

_____ _____

Signature of Patient or Patient's Representative/Parent Date

_____

Printed Name of Patient or Patient's Representative/Parent

_____

Relation to Patient