PILL HILL PODIATRY GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of
(Name of Patient)
Pill Hill Podiatry Group's Notice of Privacy Practices. This Notice describes how Pill Hill Podiatry Group may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____
(Signature of Patient, or Personal Representative) (Date)

_____
(Relationship to Patient)