



Patient Acknowledgment of Notice of HIPAA Privacy Practice

Patient name: _____

Thank you very much for taking time to review how we are carefully using your health information. We would appreciate acknowledging your receipt of our policy by signing this form to be kept with your records.

If you have any questions, please call our office at 303-796-7676.

Patient signature:

Legal Guardian if patient is a minor: _____

Date: _____