



**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

DATE: _____/_____/20_____

PATIENT'S PRINTED NAME: _____

I have received a copy of **JOHNSON MEDICAL ASSOCIATES'** Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that the practice reserves the right to change the items of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature of Patient or Representative

DATE: _____/_____/20_____

Relationship to patient (if signed by a personal representative of patient.)