

SEACOAST ORTHOPEDICS & SPORTS MEDICINE

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (603) 742-2007, on this Practice's website at sosmed.org, or by requesting one at the office.

(Please Print your Full Name)

DOB: _____

(Signature)

____/____/_____
(Date)

As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

(Please Print your Name)

(Relationship)

(Signature)

____/____/_____
(Date)