NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge I have had the opportunity to view and receive a copy of Elevate Health's "Notice of Privacy Practices".

Patient Name:

Patient Signature or Guardian	Date
Description of Guardian's Authority, if required:	

(OFFICE USE ONLY)

A written acknowledgement of receipt of the Notice of Privacy Practices was not attained, despite our best efforts, because:

- The patient refused to sign
- The patient was physically unable to sign
- Other: _____

_____

Initials: _____