



KAPLA MEDICAL GROUP  
FAMILY PRACTICE & HIV MEDICINE

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been informed of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by E-mail at:

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Print name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If this form is not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
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Patient's name: \_\_\_\_\_