Medical Record Number: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that on _____ I received the Notice of Privacy Practices of Alliance Citizens Health Association, which sets forth the ways in which my personal health information may be used or disclosed by Alliance Citizens Health Association, and outlines my rights with respect to such information.

_____ _____

Patient's signature Date

_____ _____ _____

Patient’s representative’s signature Relation to patient Date