



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have been given a copy of Northern Arizona Orthopaedics notice of privacy practices that describes how my health information is used and shared. I understand that Northern Arizona Orthopaedics has the right to change this notice at any time. I may obtain a current copy by contacting the doctor's office at any time.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

If signed by legal representative, relationship to patient \_\_\_\_\_