

Florida Foot & Ankle Associates, LLC

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally was offered and/or received a copy of Florida Foot & Ankle Associates, LLC's Notice of Privacy Practices on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

FOR OFFICE USE ONLY

G Patient/Representative Unable to Sign - Notice of Privacy Practices Provided

G Patient/Representative Refused to Sign - Notice of Privacy Practices Provided

G Other _____

Signature: _____ Date: _____

Print Name: _____