

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the Notice of Privacy Practices for Armstrong Orthopedic Associates, L.L.C.

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Personal Representative \_\_\_\_\_

Refused to sign

Name of Personal Representative (if applicable): \_\_\_\_\_

Relationship to Patient (or other authority, if applicable): \_\_\_\_\_