THE SKILL TO HEAL. THE SPIRIT TO CARE.

Written Acknowledgment of Receipt Of Florida Physicians Medical Group's Notice of Patient Privacy Practices

By signing this Written Acknowledgment, I hereby expressly acknowledge my receipt of FPMG's Notice of Patient Privacy Practices.

____
Patient, or Legal Representative, Signature

____
Printed Patient, or Legal Representative Name

____
Relationship to Patient

____
Date

Acknowledgment **NOT** obtained because:

____ Patient, or legal representative, declined to accept Notice of Patient Privacy Practices:

____ Patient received Notice of Patient Privacy Practices, but refused to sign Acknowledgement.

____ Other (briefly describe) ____

____

____
Employee Signature

____
Employee Printed Name

____
Date