NOTICE OF PRIVACY PRACTICES:

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I was provided a copy of the Facility's Notice of Privacy Practices.

Patient's Signature or Legal Representative			Date	Time
Relationship to Patient		Interpreter, If Utilized	Date	Time
Witness Signature	Date	Time		

Physician Practice

Notices of Privacy Practices Acknowledgement Form

Patient Label

Lancaster Orthopaedics & Sports Medicine