

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice, Interlake Psychiatric Associates, PLLC.

Print Name of Patient: _____
Signature of Patient: _____
Date: _____
Patient's Date of Birth: _____
Patient's ID/Chart Number: _____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____
Describe Personal Representative
Relationship (parent, guardian, etc): _____
Signature of Personal Representative: _____
Date: _____

For Practice Use Only:

Signature of Practice Employee

Date