Riverside Orthopaedic and Sports Medicine ASSOCIATES

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (*please print)* Date

Parent or Authorized Representative (*if applicable)*

Patient Signature

Rev. 1/1/13