Patient: _____

Last Name First Name M. I. SSN

Drs. Murray, Murray & Groves (the "Practice") **Acknowledgement of Receipt of Notice of Privacy Practices**

In general, any information that is about your health, the health care you receive or payment for that care is considered confidential and protected by practice. We may need to use your protected health information to carry out treatment, payment, health care operations and/or other purposes. Our Notic Privacy Practices provides a more complete description of permitted uses and disclosures.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Drs. Murray, Murray & Groves.

_____ _____

Signature of patient or patient's representative Date

Printed name of patient or patient's representative: _____

Relationship to the patient _____