

**Acknowledgement of Receipt of Notice Privacy Practices**

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Lifescope Medical Associates, P.C., which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

\_\_\_\_\_  
Signature of the Patient or the Patient's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

**FOR OFFICIAL USE ONLY**

I, \_\_\_\_\_, made a good faith effort to obtain written acknowledgement of \_\_\_\_\_'s receipt of the Notice of Privacy Practices of LifeScape Medical Associates, P.C. However, I could not obtain written acknowledgement because:

- Individual refused to sign this Acknowledgement
  - Communications barrier prohibited obtaining written acknowledgement
  - An emergency situation prevented obtaining written acknowledgement
  - Other (please specify) \_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_