

SCARLETT KROENCKE, D.P.M.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of
(Name of Patient)
Scarlett Kroencke, D.P.M.'s Notice of Privacy Practices. This Notice describes how Scarlett Kroencke, D.P.M. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

(Signature of Patient, or Personal Representative)

(Date)

(Relationship to Patient)