ACKNOWLEDGE 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 choose) and understood the Notice.

____

Patient Name (please print)

____ ________________

Parent or Authorized Representative (if applicable) Date

____

Patient Signature

Peabody Podiatry

6 Essex Center Drive, Suite 208

Peabody, MA 01960