## Written Acknowledgment of Receipt
## Of Florida Physicians Medical Group's Notice of Patient Privacy Practices

By signing this Written Acknowledgment, I hereby expressly acknowledge my receipt of FPMG's Notice of Patient Privacy Practices.

_____
Patient, or Legal Representative, Signature

_____
Printed Patient, or Legal Representative Name

_____
Relationship to Patient

_____
Date

Acknowledgment **NOT** obtained because:

____ Patient, or legal representative, declined to accept Notice of Patient Privacy Practices:

____ Patient received Notice of Patient Privacy Practices, but refused to sign Acknowledgement.

____ Other (briefly describe) _____

_____

_____
Employee Signature

_____
Employee Printed Name

_____
Date