

**Please Complete Highlighted Blue Section Only**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our *Notice of Privacy Practices*, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (949) 645-2930.

By signing this form, you acknowledge receipt of the *Notice of Privacy Practice* of Robert Skversky, M.D. (Weight No More)

*Please print your name here*

*Signature*

*Date*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*)

*Employee Signature*

*Date*