ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
CAMPBELL FAMILY PRACTICE AND INTERNAL MEDICINE ASSOCIATES

I, **[name of patient]** _____, acknowledge and agree that I have reviewed a copy of **Campbell Family Practice and Internal Medicine Associates' Notice of Privacy Practices**. I agree a photocopy of this document is valid.

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to patient

Additional Patients

Patient Name	Date of Birth	SSN

Clinic Use Only:

Campbell Family Practice and Internal Medicine Associates made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: [Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]:

_____

_____

_____

_____ _____
Signature of Employee Date

_____ _____
Print Name of Employee Title

Revised: June 5, 2003