## Acknowledgement of Receipt of Notice of Privacy Practices

**Patient Name:** _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Ventura County Hematology Oncology Specialists.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

### CONTACT INFORMATION

*The contact information of the patient or personal representative who signed this form should be filled in below.*

Address:

_____

_____

Telephone:

_____ (daytime)

_____ (evening)