



THE SKILL TO HEAL. THE SPIRIT TO CARE.

**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