

Notice of Privacy Practices Acknowledgment

I, _____, acknowledge I have received a copy of the notice of privacy practices from the Sleep Disorders Center of Alabama.

Signature of Patient or Personal Representative
(please print)

Name of Patient or Personal Representative

Date

Relationship to patient (or other authority to serve)

If patient or personal representative is unable or refuses to sign the form, document the reasons on this form. Place this form in the patient's medical record.