



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