

## Receipt of Notice of Privacy Practices Acknowledgment

I hereby acknowledge that I was offered a copy of LMEP's Notice of Privacy Practices (HIPAA), which sets forth the ways in which my personal health information may be used or disclosed by LMEP providers, and outlines my rights with respect to such information.

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Signature of Patient

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Date

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Parent / Legal Guardian Signature

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Date

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Staff / Witness Signature

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Date