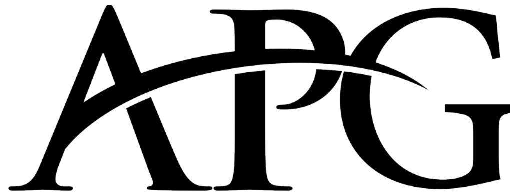

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE ASSOCIATED PHYSICIANS GROUP

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practice describes the uses and types of disclosures of my protected health information that might occur throughout my medical treatment, payment of bills or in the performance of Associated Physicians Group's health care operations. The Notice of Privacy Practice also describes my rights and Associated Physicians Group's duties with respect to my protected health information.

The Notice of Privacy Practice is available at Associated Physicians Group's office. Associated Physicians Group reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices upon a written or verbal request.

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Signature of Patient or Personal Representative

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Printed Patient Name or Personal Representative

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Date

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Description of Personal Representative's Relationship