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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge *Fal River Health Center of Maine Center for Integrative Medicine* has given you a copy of its Notice of Privacy Practices for your perusal (and a copy of the document if you so desire). This notice explains how your health information will be handled.
HIPAA, the new Federal law concerning medical privacy requires this notice.

I have read a copy of the Notice of Privacy Practices. This office has given me the opportunity to ask any questions about this notice and all of my questions have been answered.

_____
Patient's Signature or Guardian Signature

_____
Date Signed