



Whole Life Health Care – Family Practice

Notice of Privacy Practices Signature Form



In compliance with the Federal Law regarding patient’s privacy, we ask you to please read the “Notice of Privacy Practices” and sign this form.

* * * * *

I _____ a patient of Whole Life Health Care – Family Practice, acknowledge that I received and read the “Notice of Privacy Practices”.

Patient Signature _____
Date

* * * * *

I _____ the parent / guardian of _____, Date of Birth _____ received and read the “Notice of Privacy Practices” of Whole Life Health Care – Family Practice.

Parent / Guardian Signature _____
Date

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