

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided Notice of Privacy Practices (“Notice”) by Dr. Sands:

- It tells me how Dr. Sands will use my health information for the purposes of my treatment or payment for my treatment.
- The Notice explains in more detail how Dr. Sands may use and share my health information for other than treatment, payment, and health care operations.
- Dr. Sands will also use and share my health information as required/permitted by law.

Patient’s Complete Legal Name: _____

(please print)

Patient’s DOB _____ Date: _____

Signature: _____

(Patient or legal representative*)