

Sparks Family Medicine

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Las Vegas, Nevada 89144

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Patient Acknowledgement of Notice of Privacy Practices

Effective date: April 11, 2003

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing, I acknowledge that I received a copy of the Notice of Privacy Practices from Sparks Family Medicine, Ltd. I understand that I may request another copy of the Notice of Privacy Practices on subsequent office visits. I also understand that any concerns about protected health information should be directed to:

The Office Manager, 653 Town Center Dr., Suite #514, Las Vegas NV 702-243-2689

Signed by: _____
Signature of Patient or Legal Guardian Date

Print Patient's Name

If Legal or Guardian or Representative:

Print Name of Patient or Legal Guardian Relationship to Patient

Patient/guardian may receive a signed copy of this authorization form upon request.