



**Written Acknowledgement of Receipt  
Of Florida Physicians Medical Group's Notice of Patient Privacy Practices**

By signing this Written Acknowledgement, I hereby expressly acknowledge my receipt of FPMG's Notice of Patient Privacy Practices.

\_\_\_\_\_  
Patient, or Legal Representative, Signature

\_\_\_\_\_  
Printed Patient, or Legal Representative Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

Acknowledgement **NOT** obtained because:

\_\_\_\_\_ Patient, or legal representative, declined to accept Notice of Patient Privacy Practices:

\_\_\_\_\_ Patient received Notice of Patient Privacy Practices, but refused to sign Acknowledgement.

\_\_\_\_\_ Other (briefly describe) \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Date