ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(HIPAA Statement)

I have received Unity Healthcare LLC's Notice of Privacy Practices and understand that my protected health information may be used by Unity Healthcare as described in the notice.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____
(Guardian if the patient is under the age of 18)

The acknowledgment expires one year from the date signed above.

FOR OFFICE USE ONLY:

Unity Healthcare Practice: _____

Patient Account Number: _____