DuPage Family Medicine

Receipt of Notice of Privacy Practices

This is written acknowledgement that, I (the patient or legal guardian) have received a copy of DuPage Family Medicine's Notice of Privacy Practices.

Date: _____

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Parent/Legal Guardian Signature: _____

Relationship to Patient: _____

******You must be able to furnish proof of relationship or authority to act for the patient upon request******