

ACKNOWLEDGMENT *of* RECIEPT *of the*
NOTICE of PRIVACY PRACTICES *of* MSW, PLLC.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by MSW, PLLC to ensure the privacy of my personal health information. I understand that this will be placed in my member chart and maintained for six years.

Patient Name (*please print*)

Date

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative

Please list below the names and your relationship of people to whom you authorize MSW, PLLC to release your private health information.

Print Name

Relationship

This form will be placed in the member's chart and maintained for six years.