**PATIENT ACKNOWLEDGEMENT**

**OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

FOR PROTECTED HEALTH INFORMATION

**Acknowledgement of Receipt of Notice of Privacy Practices:** I acknowledge that I have been provided a copy of the Long Island FQHC, Inc. (LIFQHC) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by LIFQHC and how I may obtain access to and control the use and disclosure of this information.

Signature of Patient or Representative: ________________________________ Date _____________

Name of Personal Representative:_______________________________
(Printed) (If Applicable)

Relationship to Patient:________________________________________
(If Applicable)