

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have
(Patient printed first and last name)
received a copy of Katrina L. Lee, M.D., P.A. NOTICE OF PRIVACY PRACTICES.

This notice describes how Katrina L. Lee, M.D., P.A. may use and disclose my
protected health information, certain restrictions on the use and disclosure of my
healthcare information and rights I may have regarding my protected health
information.

(Patient or Guardian Signature)

(Date)

(Relation to Patient)