

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. I authorize treatment by Dr. Mark Light, Dr. Robert Heden and East Cobb Foot & Ankle Care.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature