

# receipt of notice of privacy practices



I \_\_\_\_\_, hereby acknowledge receipt of DuPage Medical Group's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the Group may use and disclose my confidential information.

Date of birth: \_\_\_\_\_

I understand that DuPage Medical Group has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PATIENT'S FILE