

## Adolescent Health Center USA

### Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, you will receive a revised copy if the terms of notice change.

I, \_\_\_\_\_ (print patient's name) have been provided a copy of Notice of Privacy Practices for the Adolescent Health Center USA.

I was given an opportunity to read the Notice of Privacy Practices.

I understand that I may ask any questions of the Adolescent Health Center USA regarding any information contained in the Notice of Privacy Practices.

Patient Signature \_\_\_\_\_

Authorized Representative of Patient, if Patient is  
under 18 years of age

\_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_