



Notice of Privacy Practices Acknowledgement

Patient Name: _____ Date of Birth: _____

I have read & received a copy of the Saline Medical Specialties Notice of Privacy Practices. I understand that Saline Medical Specialties has the right to change its Notice of Privacy Practices from time to time and that I may contact Saline Medical Specialties at any time to obtain a current copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Relationship: _____