NORFOLK CENTER FOR CANCER CARE & HEMATOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of
(Name of Patient)
Norfolk Center for Cancer Care & Hematology's Notice of Privacy Practices. This Notice describes how Norfolk Center for Cancer Care & Hematology 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.

_____

(Signature of Patient, or Personal Representative) (Date)

_____

(Relationship to Patient)