Patient Privacy Policy Acknowledgment

Date: _____

Patient Name: _____

Date of Birth: _____

Dear [Patient's Name],

We are committed to protecting your privacy and ensuring the confidentiality of your medical information. In accordance with HIPAA regulations, we ask that you acknowledge the receipt of our Privacy Policy which outlines how we manage your health information in relation to specialized treatments.

Please read the Privacy Policy carefully. By signing below, you acknowledge that you have received, read, and understood our Privacy Policy.

Patient Signature: _____

Date: _____

If you have any questions regarding the Privacy Policy, please do not hesitate to contact our office.

Thank you for your cooperation.

Sincerely,

[Your Name]

[Your Title]

[Your Clinic/Hospital Name]

[Contact Information]