

# NORTEX REHABILITATION

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in this notice.

Signature

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of Notice of Privacy Practices.

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Name of Patient (Print or type)

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Signature of Patient

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Date

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Signature of Patient Representative  
(Required if patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient