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Naturopathic Medicine
Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Dr. Aschtgen's *Notice of Privacy Practices* detailing how my health information may be used and disclosed under federal and state law.

I wish to have the following restrictions to the use or disclosure of my health information:

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_____ _____

Print Patient's Name *Patient's Signature* *Date*

_____ _____

Print Name of Guardian or Responsible Party *Signature of Guardian/Responsible Party* *Date*

FOR OFFICE USE ONLY

☐ Patient refused to sign *Acknowledgement of Receipt of Privacy Practices*

☐ Patient was unable to sign *Acknowledgement of Receipt of Privacy Practices* due to reasons specified below.

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Provider's Signature *Date*