N A N C Y C. W H E E L E R , M . D . , P . A.

ACKNOWLEDGEMENT OF RECEIPT:

Notice of Privacy Practices Regarding Your Health Information

Please review the Notice of Privacy Practices regarding your health information and inform Dr. Nancy Wheeler of any questions you may have regarding her policies, procedures, and/or use of your private health information.

Also, if you would like to have additional restrictions placed on your private health information, please inform Dr. Wheeler in writing.

Acknowledgement:

I have been provided a copy of the Notice of Privacy Practices regarding my health information.

Signature _____ **Date** _____

Printed Name _____

Signature of Guardian

(if patient is a minor) _____

Printed Name _____