



**Acknowledgement of Receipt of the Notice of Protected Health Information**

I have received a copy of the Notice of Privacy Practices regarding my Protected Health Information (PHI) from Center for Integrative Health and Performance

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Received by \_\_\_\_\_ Date \_\_\_\_\_  
(Medical director/representative)