

## Acknowledgement Form

The purpose of this form is for you to sign to acknowledge that you have received a copy of our Notice of Privacy Practices.

### Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Greater Philadelphia Cancer and Hematology Specialists, PC.

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**Signature of Patient or Personal Representative**

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**Date**

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**Print Name of Patient/Personal Authority**

### CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

**Address:**

\_\_\_\_\_  
\_\_\_\_\_

**Telephone:**

\_\_\_\_\_ (daytime)

\_\_\_\_\_ (evening)