ALABAMA ONCOLOGY

## Acknowledgement of Receipt of Notice of Privacy Practices

**Patient Name:**_____

**Date of Birth:** _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Alabama Oncology.

_____
Signature of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's 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)