

Bay Harbor Family Medicine

Patient's Name: _____

Patient's Date of Birth: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of Hamot Health Foundation's Notice of Privacy Practices.

(Signature of Patient/Legal Representative)

(Date)

If you are the legal representative of the person listed above, please note the basis for your authority and provide appropriate documentation:

Power of Attorney

Guardianship Order

Parent of Minor

Other _____

Hamot
**Acknowledgment of Receipt
of Notice of Privacy Practices**