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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received the Advanced Allergists Notice of Privacy Practices.

\_\_\_\_\_  
Print name of patient

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of person signing if different than patient

\_\_\_\_\_  
If person signing is a representative, describe the basis for the patient's authority to sign on behalf of patient.