

## **Acknowledgement of Receipt of Notice of Privacy Practices for Protected Health Information**

I acknowledge that I have received the Notice of Privacy Practices for Orthopedic Associates of Lancaster, Ltd.

\_\_\_\_\_  
Signature of patient, power of attorney, or guardian if minor

\_\_\_\_\_  
Date

**Email Address: (optional)** \_\_\_\_\_

(This would be used to notify you of any education programs presented by our physicians)