SLEEP MEDICINE SPECIALISTS OF SOUTH FLORIDA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____, acknowledge and agree that I have received a copy of Sleep Medicine Specialists of South Florida, PA's Notice of Privacy Practices.

_____	_____
Patient Signature	Date
_____	_____
Patient Legal Representative (if applicable)	Date
_____	_____
Print Name of Legal Representative	Relationship to Patient

FOR PRACTICE USE ONLY:

Sleep Medicine Specialists of South Florida, PA made the following good faith efforts to obtain the above-referenced Patient's written acknowledgement of receipt of the Notice of Privacy Practices: