

**ACKNOWLEDGEMENT OF UNDERSTANDING
AND/OR
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I am aware of and understand the medical privacy practices and that a copy of the Notice of Privacy Practices is available for my review upon request at the office of Bryan R. Kolber, DPM.

Printed Patient Name

Date

Signature of Patient, Parent or
Authorized Representative

** If you would like a copy of this policy please advise the receptionist. Thank You. **

_____ copy of HIPAA policy given to patient _____(staff initials)