

**Summit Family Practice**  
**NOTICE OF PRIVACY PRACTICES**

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_, acknowledge and agree that I have reviewed a copy of Summit Family Practice's Notice of Privacy Practices. I acknowledge that I may request a copy of the notice at any time.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
Patient or Legal Representative