PATIENT NAME: ______________________________

Fallbrook Family Health Center, 755 Fallbrook Blvd., Suite 100,
Lincoln, NE 68521 (402) 441-3575

Patient Acknowledgement of Receipt of the Notice of Privacy Practices

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices of Fallbrook Family Health Center.

I have the right to review the Notice of Privacy Practices prior to signing this form. If I do not sign this form, Fallbrook Family Health Center may decline to provide treatment to me.

Fallbrook Family Health Center reserves the right to revise its Notice of Policy Practices at any time. A copy of such revisions is available upon written request.

______________________________	________________________
Signature of Patient or Legal Guardian	Print Name of Legal Guardian
______________________________	________________________
Print Name of Patient	Date