



Community Care Physicians

**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have received a copy of Community Care Physicians,  
Print Patient Name

Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date