



ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of, or the option of reading the Notice of Privacy Practices of Dolphin Medical Group. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at 941-792-7400 or 941-776-1400.

If you have any questions about our Notice of Privacy Practices, please contact the Practice Manager at the telephone number listed above.

I acknowledge receipt of, or the option of reading the Notice of Privacy Practices of Dolphin Medical Group.

Signature (patient, parent, guardian)

Date

INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained:

Signature of provider representative

Date