Arthur Rosner M.D.

1055 South Boulevard E, Suite 100, Rochester Hills, MI 48307

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arthur Rosner M.D. reserves the right to modify the privacy practices as outlined.

I have received a copy of the Notice of Privacy Practices

_____ Date_____

Signature of patient

_____

Printed name

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____

Representative name Signature of representative

_____

Relationship to patient

For Arthur Rosner M.D. use only

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made good faith effort to obtain a written acknowledgement of receipt of Arthur Rosner, M.D.'s Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign
□ Patient unable to sign
□ Other _____

_____ _____

Employee name Date