

**Patient's Name:**  
\_\_\_\_\_  
**Patient's Medical Record Number:**  
\_\_\_\_\_  
**Patient's Date of Birth (mm/dd/yyyy)**  
\_\_\_\_\_



**ACKNOWLEDGEMENT  
OF  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a written copy of the Steve King, D.O., P.C. Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

\_\_\_\_\_  
Signature of Patient or Authorized Agent

\_\_\_\_\_  
Date

**TO BE COMPLETED BY STEVE KING, D.O., P.C.  
IF NO ACKNOWLEDGEMENT CAN BE OBTAINED**

Good faith efforts were made to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, were:

- \_\_\_\_\_ Patient (or authorized agent) refused to sign after being requested to do so.
- \_\_\_\_\_ Minor presented without parent or authorized agent. Notice of Privacy Practice, acknowledgement form, and self addressed envelope were sent home with the patient.
- \_\_\_\_\_ Other (please describe): \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Steve King, D.O., P.C.

\_\_\_\_\_  
Date