Acknowledgement of Receipt of Notice of Privacy Practices
NHO Radiation Oncology

Patient Name: _____

Date of Birth: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of NHO Radiation Oncology.

_____

Print Name of Patient or Personal Representative

_____

Signature of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority, if patient is unable to sign