Sheo P. Sharma M.D., P.A., F.A.C.O.G.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices for Sheo P. Sharma M.D., P.A., F.A.C.O.G.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information.

I, _____ have received a copy of
Patient Name

Dr. Sheo P. Sharma's Notice of Privacy Practices.

_____ _____
Signature of Patient **Date**

INABILITY TO OBTAIN ACKNOWLEDGEMENT

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

_____ _____
Signature of provider representative **Date**