RECEIPT ACKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the Notice of Privacy Practices of R. Craig McKee, M.D., LLC describing how medical information about me may be used and disclosed and how I can get access to this information.

Patient Name _____ Patient DOB_____

Patient Signature _____ Date _____

If the signature is not that of the patient, please indicate the legal relationship to the patient:

_____