ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ______________________________ acknowledge that I have received a copy of Cornerstone Medical Associates, LLC *Notice of Privacy Practices*. This Notice describes how Cornerstone Medical Associates, LLC may use and disclose my protected health information, certain restrictions on the use of disclosure of my healthcare information, and rights I may have regarding my protected health information.

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Signature of Patient or Personal Representative Date

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Relationship to Patient