ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

U.S. SLEEP DIAGNOSTICS

By signing below, I acknowledge that I have been provided a copy of **U.S. SLEEP DIAGNOSTICS's** Notice of Privacy Practices.

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Signature

____
Patient Name or Personal Representative (please print)

____
Date

____
Description of Personal Representative's Authority

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify):

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Effective Date of Notice of Privacy Practices Provided to the Patient:
January 1, 2010