

# Acknowledgement of Receipt of NOTICE OF PRIVACY PRACTICE

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I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practice. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

IF NOT SIGNED by PATIENT, please indicate:

Relationship:

\_\_\_ Parent or guardian of minor patient

\_\_\_ Guardian or conservator of an incompetent patient

\_\_\_ Beneficiary of personal representative of a deceased patient

Signed: \_\_\_\_\_ Date: \_\_\_\_\_