



**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of the

**HIPAA 2013
Notice of Privacy Practices**

from

University of Maryland Faculty Physicians, Inc. (FPI),
FPI's affiliated Clinical Practice Groups and/or
the University of Maryland School of Medicine

Signature of Patient or Patient's Authorized Representative Date

Print Patient Name or Name of Patient's Authorized Representative

Relationship of Person Signing (if other than Patient)

If NOT signed, please indicate reason:

This acknowledgment is effective 9/23/13 and replaces earlier versions.