

**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices for
GARY DRILLINGS, M.D. P.A.

Print Patient Name: _____

Signature of Patient: _____ *

Date: _____

*If person signing is not the patient, please print your name and relationship to patient:

Name _____

Relationship _____

I [patient or representative] request a copy of the Notice of Privacy Practices: Yes _____
No _____

For Office Use:

If patient/representative requested copy of Notice, date copy was provided:
_____.

If no acknowledgment could be obtained, state the reasons why and the efforts taken to
try to obtain the acknowledgment: _____
