

Acknowledgment of Receipt of Notice of Privacy Practices

Northeastern Asthma & Allergy, Assoc. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **Northeastern Asthma & Allergy, Assoc.**

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

Relationship of Patient Representative to Patient