Natural Medicine of NH, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, ___________________________________, hereby acknowledge that Natural Medicine of NH, LLC has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Lisa Klasman, ND
(603) 809-2620

I also understand that I am entitled to receive updates upon request if Natural Medicine of NH, LLC amends or changes its Notice of Privacy Practices in a material way.

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Signature

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Relationship to patient, if signed by someone other than the patient

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Date