

**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I have received the Notice of Privacy Practices from Direct Access Therapy that provides detailed information about how the practice may use and disclose my confidential information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
If you are not the patient, please specify your relationship to the patient.