

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

**Larry J Kaufman MD, LLC**

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices for the practice of Larry J Kaufman MD, LLC.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
If signed by personal representative, relationship to parent