

**Dakota Rehabilitation Center  
Acknowledgement of Receipt of Notice**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

If not signed by the patient, please indicate.

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative

Name of Patient: \_\_\_\_\_

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**For Office Use Only**

Signed form received by: \_\_\_\_\_

Acknowledgement refused:

Efforts to obtain:

\_\_\_\_\_  
\_\_\_\_\_

Reasons for refusal:

\_\_\_\_\_  
\_\_\_\_\_