ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been provided with a copy of the notice of privacy practices for D'nese Sokolowski, M.D., F.A.C.O.G., P.C.

X_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

Effective date: _____ _____

Staff initials