

PATIENT LABEL
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**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

- Over 18 years of age
- Under 18 years of age
- Emancipated minor child
- Over 18 but still dependent

**ACKNOWLEDGEMENT**

*I acknowledge that I have received Cedar Creek Hospital's Notice of Privacy Practices.*

Patient's Signature:	
Date:	Time:
Patient's Authorized Representative Signature:	
Date:	Time:
Witness Signature:	
Date:	Time:

**Patient is unable to sign this receipt because:**

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**Patient indicated exceptions to the use or disclosure of his/her protected health information. Those requested exceptions are as follows:**

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