



Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of Dupage Medical Group's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the Group may use and disclose my confidential information.

I understand the DuPage Medical Group has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: _____

Date: _____

Relationship: _____

