ACKNOWLEDGEMENT OF PRIVACY NOTICES

1. By signing below, I hereby acknowledge that I may review, on request, The Notice of Privacy Practices (“Notice”) from the office of **Samuel J. Mucci, M.D., P.C.**

2. **Samuel J. Mucci, M.D., P.C.** is also compliant with the “Red Flags Rule” for identity theft prevention and detection. A copy of the Policies and Procedures are available upon request.

3. I understand the content of the “Notice” and the “Red Flags Rule” and have received answers to any questions or concerns.

____
Print name of patient

____ _______________
Signature (Patient) Date

____ _______________
Signature (Authorized Rep) Date