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# The Center for Respiratory and Sleep Disorders

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44000 West 12 Mile Road, Suite 113, Novi, MI 48377 **248.465.9253 (WAKE)**  
HAAPANIEMI, LESSER ASSOCIATED, L.L.P.

## Acknowledgment of Receipt of Notice of Privacy Practices

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I acknowledge that I was provided a copy of the Notice of Privacy Practices maintained by my health care provider when I sought health care treatment. I understand that if I presented to my health care provider with an emergency condition or injury, the Notice of Privacy Practices was provided as soon as reasonably practicable after the emergency condition or injury.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

If this Acknowledgment is signed on behalf of the patient, the person's authority to sign for the patient must be indicated.

Person Signing on Behalf of the Patient:

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

Legal Authority \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

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If the Acknowledgment is not signed by the patient or legal representative, document the reason for not obtaining the Acknowledgment, and the good faith efforts to obtain the Acknowledgment.