

**Medical Oncology Hematology Consultants, PA**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**Patient Name** \_\_\_\_\_

**By signing below, I acknowledge that I have received a copy of the  
Notice of Privacy Practices of Medical Oncology Hematology  
Consultants, PA.**

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Name of Personal Representative (if appropriate)**

\_\_\_\_\_  
**Date**