

# **BAY AREA FAMILY PHYSICIANS, P.C. NOTICE AND ACKNOWLEDGEMENT**

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I acknowledge that I have received the attached Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Personal Representative  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: \_\_\_\_\_