MR#___________

SELMA MEDICAL ASSOCIATES, INC.
104 Selma Drive
Winchester, VA 22601
(540) 678-2800

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, **[name of patient]** ___________________________, acknowledge and agree that I have been given the opportunity to receive a copy of **Selma Medical Associates, Inc.**'s Notice of Privacy Practices.

________________________________	____________________
Patient Signature	Date
________________________________	____________________
Patient Legal Representative (if applicable)	Date
________________________________	____________________
Print Name of Legal Representative	Relationship to patient

FOR SELMA MEDICAL ASSOCIATES, INC. USE ONLY: (Only to be used if patient refuses to or is not able to sign)

Selma Medical Associates, Inc. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]

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____________________________________ ____________

Selma Medical Associates, Inc. Staff Signature **Date**