

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I acknowledge that I have received a copy of West Wichita Family Physicians, P.A. Notice of Privacy Practices.

\_\_\_\_\_  
(Please Print) Patient Name

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

\_\_\_\_\_  
Signature of Patient/Patient Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date