



## **Acknowledgment of Notice of Privacy Practices**

\_\_\_\_\_  
**Name of Patient (please print)**

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

**I hereby acknowledge that I received Colorado Center for Arthritis & Osteoporosis, PLLC's Notice of Privacy Practices.**

\_\_\_\_\_  
**Signature of patient or patient representative**

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