



Colorado Center  
for Arthritis & Osteoporosis, LLC

## **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, LLC's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Guardian  
(If patient is under 18)

\_\_\_\_\_  
Date