SHREVEPORT INTERNAL MEDICINE
1449 East Bert Kouns, Suite 100
Shreveport, La. 71105

PRIVACY NOTICE ACKNOWLEDGEMENT FORM

I hereby acknowledge receipt of Shreveport Internal Medicine, LLC's Notice of Privacy Practices and have been provided with the opportunity to review it.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient Signature Date

If you are not the patient, indicate your relationship below:

____ Parent or legal guardian of the minor

___ _Spouse

____ Personal representative of the patient

____ Other

Name: _____

Address: _____

Telephone: _____