

**HEIDI M. LARSON, M.D.**

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**ACKNOWLEDGMENT OF RECEIPT OF  
“NOTICE OF PRIVACY PRACTICES”**

Please sign below and return this form to the receptionist so that we know you have received our Notice of Privacy Practices.

I acknowledge receipt of the Notice of Privacy Practices prepared by Heidi M. Larson, M.D. Also, I acknowledge that I have had an opportunity to ask questions about the practice's Notice of Privacy Practices.

\_\_\_\_\_  
Name of Patient or Legal Guardian: (please print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Signature:

Date: \_\_\_\_\_