

**ACKNOWLEDGEMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

Federal law requires that we seek your acknowledgement of receipt of this Notice of Privacy Practices.

I acknowledge that I have received this Notice of Privacy Practices and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer of Stark Medical Specialties, Inc.

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

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

Print Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Signature of Parent/Guardian/Power of Attorney (specify which):

\_\_\_\_\_

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

For Office Use Only:

Signed Acknowledgement of Receipt on \_\_\_\_\_ Initials \_\_\_\_\_

Notice of Privacy Practices sent/delivered on \_\_\_\_\_ Initials \_\_\_\_\_

Patient Refused or Failed to Acknowledge Receipt on \_\_\_\_\_ Initials \_\_\_\_\_

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