

Lehigh Family Medicine, LLC
525 Iron St Suite B
Lehigh, Pa 18235

Acknowledgement of Privacy Practices

Patient Name: _____
Print Name

I have received a copy of the Lehigh Family Medicine, LLC "Notice of Privacy Practices" on: _____ / _____ / _____
Month Day Year

Phone numbers are listed on the "Notice of Privacy Practices" should I have any questions. I understand a copy of this notice is available for viewing at any time at www.LehighFamilyMed.com

Signature: _____
Signature of Patient or Legal Representative/Witness

Print Name: _____
Legal Representative (if different from patient include relationship)