

ACKNOWLEDGEMENT FORM

**THE FERTILITY CENTER, LLC
130 LEADER HEIGHTS ROAD
YORK, PA 17403
717-747-3099**

Date: _____

I have received a copy of the document entitled:

NOTICE OF PRIVACY PRACTICES

from The Fertility Center, LLC. This copy of the document remains mine for the purposes of my own record. I am aware that I may request an additional copy of this document at any future date during the duration of my treatment and care at this office.

This original signed acknowledgment document will be kept in my medical file at this office.

Signature of Patient (or guardian of patient)

Date

Printed Name of Patient (or guardian of patient)

Date

Witness to the signature

Date