NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT RECEIPT

I hereby acknowledge that I received the Kettering Medical Center Network's Notice of Privacy Practices which sets forth the ways in which my personal health information may be used or disclosed by the Kettering Medical Center Network, and outlines my rights with respect to such information.

_____	_____
Patient's signature	**Date**
_____	_____
Legally Authorized Representative	**Authority**