

**LAWRENCE J. CONELL, M.D., PLC  
110 NEWMAN AVENUE  
Harrisonburg VA 22801**

**Acknowledgement of Receipt of  
Notice of Privacy Practices**

By signing this form, you acknowledge that this Medical Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the new Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. The Medical Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered.

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Patient's Signature or Guardian

You may discuss my medical condition with:

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Date Signed

**Provider Use Only**

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below.

Patient was given the notice \_\_\_\_\_ Yes \_\_\_\_\_ No

Reason signature was not obtained \_\_\_\_\_

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Staff Signature

Date