



HIPAA COMPLIANCE PLAN – PRIVACY RULE

Oasis MSO, Inc.

**PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices**

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for the medical practice of Oasis MSO, Inc.

\_\_\_\_\_  
Name of Patient *Please Print*

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative  
(Required if the patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient