



## Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of Dr. Ann Liebeskind and Mobile Health Team.

I hereby acknowledge receipt of the Coraggio, LLC D/B/A Mobile Health Team Notice of Privacy Practices.

**Adult Patient:**

Name [please type]: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

PHONE: 844.547.4343(844.LIPID.HELP) • FAX: 888.806.8148