

**CREIGHTON UNIVERSITY**  
**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

The undersigned acknowledges receipt of Creighton University's Notice of Privacy Practices.

Patient Name (Please Print): \_\_\_\_\_

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Parent or Legal Representative  
(if Patient is under 19)

\_\_\_\_\_  
Date