

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices for Sheridan Healthcare, Inc. and its affiliated entities and subsidiaries. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996.

Effective Date of Notice: April 14, 2003

Patient: _____

Date: _____

or

Patient's Representative: _____

Date: _____

Relationship to Patient: _____