

---

**ERIC S. ALBRIGHT, M.D., P.C.**

HARVARD PARK MEDICAL PLAZA  
950 E. HARVARD AVENUE  
SUITE 660  
DENVER, COLORADO 80210-5051  
720-399-6555  
FAX - 720-399-0511

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I received Dr. Albright's Notice of Privacy Practices.

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

---