Department of Veterans Affairs	**Acknowledgement of the Notice of Privacy Practices**

Acknowledgement of Department of Veterans Affairs, Veterans Health Administration

VHA Notice of Privacy Practices

The signature below only acknowledges receipt of the VHA Notice of Privacy Practices.

_____ Signature of Patient/Patient Representative	_____ Date
_____ Name of Patient/Representative	_____ Relationship to patient (if applicable)
_____ Last four SSN	

VA Form
10-0483