

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Aurora Therapeutics, Inc. has offered to provide me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I have read them or declined to read them. I understand that if I have questions or complaints I may contact their office.

I also understand that I am entitled to receive updates upon request if Aurora Therapeutics, Inc. amends or changes its Notice of Privacy Practices in any way.

Client Name (please print)

Client Signature

Relationship to Client, if signed by someone other than client.

Date

**THIS SECTION IS TO BE COMPLETED BY AURORA THERAPEUTICS, INC.
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT**

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgment.
- Other (specify): _____

Name and title of employee

Date