MARSH BROOK REHAB
Patient-focused. Results-driven.

# Acknowledgement of Notice of Privacy Practices For Protected Health Information

I acknowledge receipt of the Notice of Privacy Practices from Strafford Health Alliance ("SHA").

I understand this Notice contains important information about how my protected health information may be used and disclosed and how I can get access to this information. I understand that SHA has the right to change this Notice at any time and I may obtain a current copy upon request.

Signature of Patient or Representative _____ Date _____