Acknowlegment of Receipt of Privacy Practices

You acknowledge that you were offered a copy of our Notice of Privacy Practices. If you would like to receive a paper copy at any time in the future, you can call

Name: _____
(Patient's Name - Please Print)

Signature: _____
(Patient or Guardian Signature)

Date: _____

Individual was unable to sign due to the following reason:

_____ Admitted directly to treatment area

_____ Left AMA or without being seen

_____ Unresponsive

_____ Not competent

_____ Refused to sign

_____ Minor Child (If under the age of 18)

Signature of facility representative:

_____

Date: _____

Please list anyone with whom we can discuss medical issues:

	Name	**Relationship**
1.	_____	_____
2.	_____	_____
3.	_____	_____