GIFT OF HEALTH
MEDICAL CENTER

PATIENT ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of Gift of Health Medical's Notice of Privacy Practices.

_____ _____

Patient Name (Print) Date

_____

Signature of patient or personal representative/Relationship to Patient

Complete this section if this form is not signed and dated by the patient or patient's representative.

The date that you requested the signature and date: _____

The reason that the signature and date were not obtained:

Refused Emergency Other

_____

_____