



MRN: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form you acknowledge receipt of the Notice of Privacy Practices for MemorialCare Medical Foundation and its affiliated medical groups. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change.

Signature of Patient /Patient Representative

Date

Name of Patient/ Patient Representative (please print)

Relationship to Patient

COMPANY USE ONLY:

We attempted to obtain written acknowledgement of patients' receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient for the following reason:

- Patient Refused to Sign
- Patient Representative Refused to Sign
- Emergency Situation Prevented Signature
- Other (please specify) _____

Provider Representative Signature

Date