PLACE LABEL OR PRINT PATIENT INFORMATION BELOW

MCC No.: _____

Patient First Name: _____

Patient Last Name: _____

Patient DOB: _____

Date of Service: _____

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Thank you for choosing Medical Center Clinic for your health care needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices ("Notice"). To ensure that our records are accurate, please sign below to acknowledge that you have been provided with a copy of our Notice.

_____ _____
Patient Signature Date of Signature

PERSONAL REPRESENTATIVE

Complete this section ONLY if you are signing this Notice of Privacy Practices as the patient's personal representative i.e., parent of minor child, power of attorney, health care surrogate, legal guardian.

_____
Personal Representative (Print Name)

_____ _____
Personal Representative Signature Date of Signature

OFFICE USE ONLY

A good faith attempt was made to obtain the patient's written acknowledgement of receipt of MCC's Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual declined to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please describe below)

_____ _____
Employee Name (please print) Date