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 __________________________

If a personal representative signs on behalf of the patient, please complete the below additional information:

Personal Representative’s Name (Print) __________________________  Relationship to Patient __________________________

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

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