

PLACE LABEL HERE OR LEGIBLY PRINT
PATIENT'S FIRST AND LAST NAME AND MCC#

Print Patient First and Last Name

Print MCC#



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