ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Drs. McCarthy, Mayfield, Silinsky & Zelhart

Notice to our Patients:

We are required to provide you with a copy of our Notice of Privacy Practices upon request, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign the acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

□ The patient refused to sign.

□ Due to an emergency situation it was not possible to obtain an acknowledgement.

□ We weren't able to communicate with the patient.

□ Other (Please provide specific details)

_____

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_____ _____

Employee signature *Date*