HEALTH CHOICE CLINIC

ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Your name and signature on this form indicates that you have received a copy of Health Choice Clinic's Notice of Privacy Practices on the date and time indicated below.

PRINTED NAME: _____

SIGNATURE: _____

RELATIONSHIPT TO PATIENT: _____

DATE RECEIVED: _____ TIME RECEIVED: _____

FOR CLINIC USE ONLY

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

- ☐ Individual Refused to Sign
- ☐ Emergency Situation Prevented Signature
- ☐ Patient Requested Above Individual Sign on His / Her Behalf
- ☐ Other (please specify) _____

Registration Representative Signature: _____

Date: _____