APEX MEDICAL CENTER
NOTICE OF PRIVACY PRACTICES:
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of APEX MEDICAL CENTER. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. I, ______________________________ acknowledge receipt of the Notice of Privacy Practices of APEX MEDICAL CENTER.

Signature: ____________________________________ Date: ________________
(patient/parent/conservator/guardian)

Relationship to Patient:

☐ Self ☐ Other: ________________________________
(Please Specify)

For Office Use Only

INABILITY TO OBTAIN ACKNOWLEDGEMENT
To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

☐ Patient refused to sign.

☐ Other Comments: Reasons why the acknowledgement was not obtained:

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Signature of provider representative: ________________________ Date: __________