PARK MEDICAL CENTERS
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

PARK MEDICAL CENTERS reserves the right to modify the privacy practices outlined in the notice.

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[ ] I have reviewed the Notice of Privacy Practices for PARK MEDICAL CENTERS.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

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If an acknowledgment was not obtained, the Medical Practice must document, in the space provided below, its good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained.

FOR PARK MEDICAL CENTERS USE ONLY

[ ] Patient/representative prefers not to sign.

[ ] Other: _____

_____

Name of Park Medical Centers Representative (print)

_____

Signature of Park Medical Centers Representative