Notice of Privacy Practices

RECEIPT AND ACKNOWLEDGEMENTS

I hereby acknowledge that I received a copy of this medical group's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signature _____ Date _____

Print Name _____ Telephone Number (_____)_____

If not signed by patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Patient's Name

First _____ Middle _____ Last _____

Patient's Address

Street _____

City _____ State _____ ZIP _____

For concerns regarding this form and Notice of Privacy Practices,
please contact Group Administrator at (562) 430-7533.