Notice Of Privacy Practices

Patient Label Here

Patient Name: _____

DOB: _____ MRN: _____

Acknowledgement of Receipt

PATIENT INFORMATION

_____ _____
Patient Name (Please Print) Patient Date of Birth

_____ _____
Patient / Guardian Signature Date

_____ _____
Patient Phone XXX-XXX-XXXX Name of Physician

By signing this form, the patient acknowledges receipt of the "Notice of Privacy Practices" of Arch Health Medical Group. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information. We encourage you to read it in full.

I acknowledge receipt of the "Notice of Privacy Practices" of Arch Health Medical Group.

_____ _____
Patient / Guardian Signature Date

_____
If legal representative, state relationship to patient

☐ I would like to receive a copy of any amended Notice of Privacy Practives via e-mail.

My email address is: _____