PLACE LABEL HERE OR LEGIBLY PRINT
PATIENT"S FIRST AND LAST NAME AND MCC#

Print Patient First and Last Name

Print MCC#

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Thank you for choosing Medical Center Clinic for your health care needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices ("Notice"). To ensure that our records are accurate, please sign below to acknowledge that you have been provided with a copy of our Notice.

Patient Signature _____ Date of Signature _____

If a personal representative signs on behalf of the patient, please complete the below additional information:

Personal Representative's Name (Print) _____ Relationship to Patient _____

OFFICE USE ONLY

A good faith attempt was made to obtain the patient's written acknowledgement of receipt of MCC's Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual declined to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please describe below)

_____

_____

Employee Name (please print) _____ Date _____