

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

Glacier Medical Associates, Inc.

I acknowledge that I have received a copy of the Clinic Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Clinic may disclose and use my protected health information.

Patient Name: _____

Signature: _____ Date: ____/____/____

If signed by the patient's personal representative, indicate:

a. Name of signer: _____

b. Relationship to patient: _____

If acknowledgment not signed, indicate reason not signed and efforts made to have acknowledgment signed:

