ACKNOWLEDGE OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Effective Date: January 1, 2003

Thank you for choosing the Medical Center Clinic for you healthcare needs.

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

_____	_____	_____
Patient Name	MCC #	Date of Birth

_____
Signature of Patient (or Legal Representative)

_____
Date

_____	_____	_____
Signature of Staff Member	Title	Date

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