FAMILY MEDICINE HEALTH CENTER

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

The Family Medicine Health Center's Notice of Privacy Practices describes how patient's medical information may be used and disclosed and your outlines rights regarding this protected information.

Your signature indicates that you have read, understand and acknowledge the FMHC Notice of Privacy Practices.

Patient Printed Name: _____

Patient Guardian Signature: _____

Today's Date: _____

FOR FMRI STAFF USE ONLY

If the patient or guardian refuses to sign / complete this form, please complete this section.

Date Offered to Patient: _____/_____/_____ **Patient ID #:** _____

Reason for Incomplete Acknowledgement: _____

FMRI Staff Printed Name: _____

FMRI Staff Signature: _____