Care Plus
FAMILY CLINIC

Acknowledgement of Privacy Policy

Patient Name: _____

Patient Date of Birth: _____

I have received the practice's Notice of Privacy Practices written in plain language and I have been provided the opportunity to review it. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practices legal duties with respect to my protected health information.

I understand the practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information it maintains. I understand I can obtain this practice's current Notice of Privacy Practices on my request.

Signature (Patient/Legal Guardian):_____

Name (Print): _____

Date: _____