LivingWell Primary Care
...We Focus on Prevention

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record Number: _____

Address: _____

Practice Name: LivingWell Primary Care

I have been given a copy of LivingWell Primary Care's (upon request) Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that LivingWell Primary Care has the right to change this Notice at any time. I may obtain a current copy by contacting the Practice Privacy Official.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices (upon request):

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Healthcare Power of Attorney

_____

For Practice Use Only" Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this Acknowledgement, of the Acknowledgement is not signed for any reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the Acknowledgement:

   _____

   _____

Completed by:

_____ _____

Signature of Practice Representative Print Name