NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

The **Reliance Medical Group, LLC,** Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we are providing you, copies of the current notice are at the Practice.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative _____ Date _____ Time _____

Print Name _____ Relationship to Patient _____

Interpreter (if applicable) _____

COMPLETE IF WRITTEN ACKNOWLEDGMENT WAS NOT OBTAINED

Please document your efforts to obtain acknowledgment and reason it was not obtained.

1. Notice of Privacy Practices Given – Patient Unable to Sign. _____
2. Notice of Privacy Practices Given – Patient Declined to Sign. _____
3. Notice of Privacy Practices and Acknowledgment Mailed to Patient. _____
4. Other Reason Patient Did Not Sign: _____

Signature of Practice Representative _____ Date _____ Time _____

Print Name _____ Department _____