ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE

<u>Acknowledgment of Privacy Practice Notice (check boxes that apply)</u>

□ I have received a copy of the Coddington Medical Family Practice, LLC Notice of Privacy Practices.

______________________________________ ____________________

Patient’s Name (printed) Date of Birth

______________________________________ ____________________

Patient’s Signature Date

Obtained by: ____

Signature and Title of Clinic Personnel Date

CMFP USE ONLY   Documentation of Good Faith Effort

□ Attempted to distribute the Notice of Privacy Rights and Practices to the patient/parent/legal guardian, but the patient/parent/legal guardian declined to sign the acknowledgment.

□ Patient/Parent/Legal Guardian stated that they had already received the Notice of Privacy Rights and Practices.

□ Patient/Parent/Legal Guardian directed CMFP's website to view the Notice of Privacy Rights and Practices.

□ The Notice of Privacy Rights and Practices was mailed to the patient/parent/legal guardian on ___________________(date)

□ Unable to obtain an acknowledgment as patient was not capable upon arrival and transferred to ___________________(other hospital/clinic name) immediately.

□ Other (explain) ____

____

Signature and Title of Clinic Personnel   Date

I Authorize CMFP to release health information (not copies of my health record) to the person or persons listed below as I consider them involved in my health care. **I understand that I may change this at any time in writing. CMFP will disclose only information that is directly relevant to the person's involvement in my health care or payment relating to my health.**

PLEASE MARK ALL THAT APPLY:

__ Spouse

__ Parents

__ Children

__ Other ____

____

Signature of Patient