Acknowledgement of Receipt of Notice of Privacy Practices

RUTH HASKINS, MD, INC.

(916) 817-2649

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, available on the practice website (www.ruthhaskinsmd.com), and that a copy of any amended Notice of Privacy Practices will be made available upon request at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

Signature not obtained:

_____ Patient unable to sign

_____ Patient unwilling to sign

_____ Notice mailed to patient, signature pending

_____ _____

Name of Practice Representative Date

Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: _____

Address: _____

_____

For Office Use Only:

Date received:	Processed by:
Practice Follow-up: Î Yes Î No	Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____