ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

ROCKDALE
Family Practice, P.C.

I acknowledge that I have been provided the ROCKDALE FAMILY PRACTICE Notice of Privacy Practices ("Notice"):

- It tells me how Rockdale Family Practice will use my health information for the purposes of my treatment, payment for my treatment, and Rockdale Family Practice health care operations.
- The Notice explains in more detail how Rockdale Family Practice may use and share my health information for other than treatment, payment, and health care operations.
- Rockdale Family Practice will also use and share my health information as required/permitted by law.
- Rockdale Family Practice may also exchange my health information for treatment purposes when participating in Health Information Exchange (HIE).

  I consent to Rockdale Family Practice using and disclosing my treatment records maintained by Rockdale Family Practice for the purposes detailed In ROCKDALE FAMILY PRACTICE Notice of Privacy Practices.

Patient's Complete Legal Name: _____
(please print)

Patient's DOB _____ Date: _____

Signature: _____
(Patient or legal representative*)

*May be requested to show proof of representative status

Office use only

I attempted to obtain the patient's signature on this acknowledgement, but was unable to do so as documented below:					
Date attempted:		Name:		Reason:	