

Rockwood Natural Medicine Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that the Rockwood Natural Medicine Clinic, has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

**Jeanne Espinoza
480-767-7119**

I Also understand that I am entitled to receive updates upon request if the Rockwood Natural Medicine Clinic amends or changes its Notice of Privacy Practices in a material way.

Signature

Relationship to Patient, if signed by
Some one other than patient.

Date

THIS SECTION IS TO BE COMPLETED BY THE ROCKWOOD NATURAL MEDICINE CLINIC IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgement.
- Other (specify): _____

Name and Title of Employee

Date

