PRIMARY CARE PARTNERS

HIPAA Acknowledgement

Notice of Privacy Practices

Print Name of Patient _____

Patient Date of Birth _____

We at Primary Care Partners are required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information. I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Signature of Patient/Legal Representative _____

Today's Date _____

Email Address of Patient/Legal Representative _____

Cell Phone of Patient/Legal Representative (_____) _____ - _____

Please let us know which number you would like us to call regarding your medical information. *Note that this is the number where we will leave a message if we do not reach you.*

☐ Home phone ☐ Cell phone ☐ Both