

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have received a copy of the New Horizons Medical Center Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in the NHMC Notice of Privacy Practices, please ask to speak with a clinic representative as indicated in your Notice.

Patient Name (printed): _____

If Patient Representative, Name (printed): _____

If Patient Representative, Relationship to Patient (printed): _____

Signature: _____

Date Notice Received: _____