Prestige
Medical Group

Acknowledgement of Receipt of Privacy Notice

I, _____ acknowledge that I have had an opportunity to review a copy and/or have been provided a copy of Prestige Medical Group's "Notice of Privacy Practices". This notice describes how Prestige Medical Group may use and disclose my protected health information, certain restrictions on the use of my healthcare information, and any rights I may have pertaining to my protected health information.

_____ _____

(Signature of Patient/Guardian/Personal Representative) (Date)

_____

(Relationship to Patient)

Office Use Only

If the patient did not sign an acknowledgement of Receipt of Privacy Practices, please complete the following.

____ Individual refused to sign

____ Communication barriers prohibited us from obtaining the acknowledgement

____ Other (specify) _____