Acknowledgement of Receipt of Notice of Privacy Practices

Complete HealthCare Medical Center, P.C. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for Complete HealthCare Medical Center, P.C.

____
Name of Patient (Print Name)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient