

CAPITAL REGION MEDICAL CLINIC

**ACKNOWLEDGEMENT OF RECEIPT  
OF  
CAPITAL REGION MEDICAL CENTER'S  
Notice of Privacy Practices**

<p>_____</p> <p>patient's name (print) or use label</p> <p>_____</p> <p>account number</p>
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I acknowledge that I have been provided with Capital Region Medical Center's Notice of Privacy Practices.

Patient or legal representative's signature: **X** \_\_\_\_\_

Date: \_\_\_\_\_

Patient was unwilling/unable to sign the acknowledgment.

Reason: \_\_\_\_\_

Staff Initials: \_\_\_\_\_

Date: \_\_\_\_\_

- While coordinating care during your treatment at Capital Region Medical Clinic, our health care professionals may be asked to discuss your health information with a family member or friend involved in your care. This could include but not be limited to: physician appointments, diet and medication instructions, and test results.

We ask that you provide names of the friend(s) and/or family member(s) who you authorize to have access to your health information.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

***Thank You. We respect your right to privacy.***