ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of, or the option of reaching the notice of Privacy Practices of Aldrich Cardiovascular Institute. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at 359-8900.

If you have any questions about our Notice of Privacy Practices, please contact the Practice Manager at the telephone number listed above.

I acknowledge receipt of, or the option of reading the Notice of Privacy Practices of Aldrich Cardiovascular Institute.

Signature (patient, parent, guardian)_____

Date_____

INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained:

_____

_____

Signature of provider representative_____

Date_____