



JAPAN TOWN MEDICAL GROUP
FAMILY PRACTICE & SPORTS MEDICINE

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended notice of Privacy Practices by e-mail at:

Name Signed _____ Date _____

Name Printed _____ Telephone _____

If not signed by the patient, Please indicate

Relationship

- Parent or Guardian of Minor Patient
- Guardian or "Conservator of incompetent person
- Beneficiary or Personal Representative of deceased patient

Name of Patient: _____



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Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: _____

Address of Patient: _____

For office use only:

Date Received:	Processed by:
Practice Follow Up: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Practice Follow Up:

Complete the following only if the Patient refuses to sign the Acknowledgment.

Efforts to Obtain: _____

Reason for refusal: _____

