ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _________________, hereby acknowledge that Nature's Helper Medical Clinic has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr. Stacey Munro
(860) 758-7808

I also understand that I am entitled to receive updates upon request if Nature's Helper Medical Clinic amends or changes its Notice of Privacy Practices in a material way.

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Patient or legally authorized individual signature Date

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Printed Name if signed on behalf of the patient Relationship

For office use only

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I made a good faith effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the above named patient, but was unable to because (please specify):

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