Milford Regional Physician Group

The Benchmark for Quality Care

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received and reviewed a copy of Milford Regional Physician Group Notice of Privacy Practices and have been offered an opportunity to request restrictions on certain uses and disclosures of my protected health information.

Signature of patient or patient representative _____ Date_____

Patient's Social Security #_____ Birthdate_____

Printed name of patient or patient's representative _____

Relationship to the patient _____

O Patient refused to sign Acknowledgment of Receipt of Privacy Notice