Tri-County Medical

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 Tri-county Medical's 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 _____

❑ Patient refused to sign Acknowledgment of Receipt of Privacy Notice