Prestige
Medical Group

# PRIVACY ACKNOWLEDGEMENT

**Prestige Medical Group**

**Acknowledgement of Receipt of Notice of Privacy Practices**
I acknowledge that I have received or have been offered a copy of Prestige Medical Group's Notice of Privacy Practices. This notice describes how my protected health information (PHI) may be used and disclosed, my rights regarding my health information, and the responsibilities of Prestige Medical Group under federal and state privacy laws.

I understand that Prestige Medical Group reserves the right to change its Notice of Privacy Practices and that a current copy will be available at the practice and on the practice website.

Patient Name: ___________________________________________

_____________________________________________ __________

Signature of Patient / Guardian / Personal Representative Date

Relationship to Patient (if not patient): ________________________________________

**Office Use Only**

If the patient did not sign an acknowledgement of receipt of the Notice of Privacy Practices, please indicate the reason below.

☐ Individual refused to sign
☐ Communication barriers prohibited us from obtaining the acknowledgement
☐ Emergency situation prevented acknowledgement at time of service
☐ Other (please specify): ___________________________________________