

# Acknowledgement of Receipt of Notice of Privacy Practices

Sun City Medical Partners  
27830 Bradley Road  
Sun City, CA 92586

Privacy Officer: Practice Manager (951) 679-2358

Effective Date: August 12, 2013

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above physicians. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**If not signed by the patient, please indicate:**

Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Communication of Personal Health Information:**

General office policy is that no information may be left with anyone but the patient. Many patients may find multiple methods of communication acceptable, even though total confidentiality cannot be guaranteed.

Below is a list of Communication Options. Please place a check mark next to the methods that are acceptable means of communicating information regarding your health. Please understand that a check mark grants us permission to **COMMUNICATE ANY AND ALL INFORMATION TO YOU IN THIS MANNER.**

- Home Answering Machine/Voice Mail  Acceptable
- Office Voice Mail  Acceptable
- Cell Phone/Voice Mail  Acceptable
- Message with Spouse/Designated Family Member  Acceptable

Name	Relationship	Phone Number

**Notice of Privacy Practices Acknowledgment Tracking Information**

*Complete the following only if the Patient refuses to sign the Acknowledgment:*

Efforts to obtain: \_\_\_\_\_

Reasons for refusal: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_