MARLBORO INTERNALMEDICINE
RELATIONSHIP ■ RESPECT ■ RESULTS

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form you acknowledge that this Medical Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled by HIPPA, the New Federal law concerning medical privacy requires this notice.

I have received a copy of this Notice of Privacy Practices. The Medical Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered.

_____
Patient's Name (Please Print)

_____ _____
Signature of Patient or Guardian **Date Signed**

PROVIDER USE ONLY

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below.

Patient was given the notice _____Yes _____No

Reason signature was not obtained:

_____
_____
_____

_____ _____
Staff Signature **Date**

FORMCCB