MyCare
HEALTH CENTER

Notice of Privacy Practices Acknowledgment Form

PART A

Name: _____ Date: _____

I received a copy of MyCare Health Center's Notice of Privacy Practices

Signature: _____ Date: _____

If signed by a Parent or Legal Representative:

_____ Relationship to Patient: _____
Print Name (Parent, Legal Representative, Guardian)

Witness: _____ Date: _____

PART B

I can be contacted regarding appointment and medical information by the following methods. Mark all that apply.

☐ Text Message to _____

☐ Email Address _____

☐ Cell Phone _____ May We Leave A Message ☐ YES ☐ NO

☐ Home Number _____ May We Leave A Message ☐ YES ☐ NO

☐ Work Number _____ May We Leave A Message ☐ YES ☐ NO

PART C

Who May We Share Your Medical Information With?

Name	Phone	Relationship

Office Use Only

Reason Individual or Legal Representative Did Not Sign This Form:
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual Declined to Sign

☐ Communication barriers prohibited obtaining the Acknowledgement

☐ An Emergency Situation Prevented us From Obtaining Acknowledgement

☐ Other (Please Specify) _____