ACKNOWLEDGEMENT OF RECIEPT OR
NORTH PHOENIX INTERNAL MEDICINE P.C
NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the opportunity to review a current copy of North Phoenix Internal Medicine "Notice of Privacy Practices". My signature means that I agree to the terms of this notice. Please return this acknowledgement of receipt of notice to North Phoenix Internal Medicine P.C. I understand that I may refuse to sign this acknowledgement.

I knowledge receipt and have read and understand the Notice of Health Information Practices regarding my Provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

_____ Date: _____
Print Patient Name or Authorized Representative

_____ Date: _____
Signature of the Patient or Authorized Representative

_____
Relationship to the Patient if signed by anyone other than the Patient

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FOR OFFICE USE ONLY

North Phoenix Internal Medicine P.C. could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to the fact:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited it
- ☐ An emergency situation prevented us
- ☐ Other (please specify) _____
  _____
  _____