Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Muslim Community Center Medical Clinic (MCCMC) Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the MCCMC Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the MCCMC's Privacy/Compliance Officer as indicated on your Notice.

Patient Name (Printed):

_____

If Patient Representative, Name (Printed):

_____

If Patient Representative, Relationship to Patient (Printed):

_____

Account # or Medical Record #:

_____

Signature:

_____

Date Notice Received:

_____

RESET PRINT

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