PrimeCare
FAMILY PRACTICE

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received, or have been offered, a copy of the Prime Care Family Practice Notice of Privacy Practices (Effective Date: April 2003. Revised: 02/13/2026). The Notice describes how my health information may be used and disclosed, and my rights regarding that information.

I understand that Prime Care Family Practice may change its Notice of Privacy Practices, and that I may ask for a current copy at any time.

Patient Name: _____ **Date of Birth:** _____

Signature of Patient or Personal Representative: _____ **Date:** _____

If signed by a personal representative

Printed Name of Representative: _____

Relationship to Patient or Authority to Act: _____

For Office Use Only

If the patient did not sign, describe the good faith effort made to obtain acknowledgment:

- ☐ Patient refused to sign
- ☐ Emergency situation prevented obtaining acknowledgment
- ☐ Other: _____

Staff Name: _____ **Date:** _____