



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received a copy of One Family Medical Group Notice of Privacy Practices.

PATIENT SIGNATURE

DATE

PARENT / GUARDIAN SIGNATURE

DATE

PATIENT LEGAL REPRESENTATIVE *(if applicable)*

DATE

PRINT NAME OF LEGAL REPRESENTATIVE

FOR CLINIC USE ONLY:

One Family Medical Group, made the following good faith efforts to obtain the above referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices:

Identify the efforts that were made to obtain the individual's written acknowledgment, including the reasons (if known) why the written acknowledgment was not obtained.

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