Patient's Name ______________________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of Hamot Health Foundation's Notice of Privacy Practices.

If you do **NOT** want messages left on your voice mail/answering machine please mark this box. ☐

______________________________________ ____________________
(Signature of Patient/Legal Representative) (Date)

If you are the legal representative of the person listed above, please note the basis for your authority and provide appropriate documentation:

_______ Power of Attorney _______ Guardianship Order

_______ Parent of Minor _______ Other _______________

Hamot Medical Center