Dr. Priscilla Monroe, RN, ND
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I,_____, hereby acknowledge that Dr. Priscilla Monroe, RN, ND has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr. Priscilla Monroe, RN, ND
916-448-9927

I also understand that I am entitled to receive updates upon request if Dr. Priscilla Monroe, RN, ND amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient, if signed by someone other than patient.

_____
Date

THIS SECTION IS TO BE COMPLETED BY DR. PRISCILLA MONROE, RN, ND IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____ _____
Name and title of employee Date