

ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices
Community Memorial Hospital
and all Programs, Departments, and Clinics

I have received a copy of the Notice of Privacy Practices for Community Memorial Hospital and all Programs, Departments and Clinics.

Date

Signature

Patient's name, (if signature obtained from family member, POA, etc. or if unable to obtain a signature.)

Staff members: Use space below to document attempts to obtain written acknowledgement.