Sanford F. White, M.D., M.P.H.
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Ensign Family Medicine is required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information.

I hereby acknowledge that a copy of the Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Ensign Family Medicine's privacy practices or my rights with regard to my personal health information, I may contact the Privacy Officer for further information as set forth in the Notice.

____ ______________________

Patient Name (please print) Date of Birth

____ ______________________

Signature of Patient (or Patient Representative*) Date

*If signed by Patient's Representative, please specify:

1. Print name of Patient's Representative:____
2. State relationship and/or authority to act on behalf of the patient:_________________________

*****FOR OFFICE USE ONLY*****

ACKNOWLEDGMENT REFUSED

On this date, the undersigned patient refused or failed to acknowledge receipt of the Notice of Privacy Practices.

___________________________________ ___________________

Patient Name (please print) Date

Reason for refusal/failure:____

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Witness (please print and sign)