Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of **ARCC's Notice of Privacy Policies** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

____

____

I have the right to change these restrictions and have the most recent authorization used.

Signed:____

Date:____

If not signed by the patient, please indicate your relationship to the patient (e.g. spouse).

Relationship:____

Witnessed by(employee):____

Privacy officer/designee signature:____

Restriction accepted: Yes____________________ **No**______________________

Patient notified of acceptance/denial: Yes______________ **No**________________

For office use only:
If patient refuses to sign, indicate your attempt to obtain a signature below.
( ) patient refused to sign this Acknowledgement.

Date:_____________ Time:____________ Reason:____________________________

____

Employee name:____