



ROSENBERG COOLEY METCALF
THE ORTHOPEDIC CLINIC AT PARK CITY

ACKNOWLEDGMENT NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of The ROSENBERG COOLEY METCALF CLINIC'S Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about The ROSENBERG COOLEY METCALF CLINIC'S privacy practices or my rights with regard to my personal health information, I may contact the appropriate person for further information as set forth in the Notice.

Name of Patient (and Patient's Representative, if one)

Patient Identification #

Signature of Patient (or Patient's Representative)

Date

Staff Use Only:

To Be Used By Office Staff Only If Patient Written Acknowledgement Is Not Obtained.

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ **Patient Identification #:** _____

I hereby certify that on ___/___/___ (MM/DD/YR), I made a good faith effort to obtain the above patient's written acknowledgement of receipt of The ROSENBERG COOLEY METCALF CLINIC'S Notice of Privacy Practices, but I was unable to do so for the following reason(s);

Name of Staff Person (Type or print)

Signature of Staff Person

Date: _____