Acknowledgement of Receipt of Notice of Privacy Practice

I have been given a copy of the Notice of Privacy Practices for the St Louis Medical Clinic that describes how the clinic may use and disclose my protected health information for the purpose of providing treatment, obtain payment for treatment, conducting healthcare operations, and as required by law.

I understand that St.Louis Medical Clinic reserves the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Clinic and requesting a coy be sent by regular mail, asking for one at the time of my next appointment, or by visiting the Clinic's website at www.stlmedclinic.com

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices for St.Louis Medical Clinic.

PRINT NAME OF PATIENT

SIGNATURE OF PATIENT

DATE

In the event the patient is a minor or you have Power of attorney for the patient, please complete below:

PRINT NAME OF PARENT OR LEGAL REPRESENTATIVE

SIGNATURE OF PARENT OR LEGAL REPRESENTATIVE

If signed by legal representative, please indicate your relationship to the patient.

Date ______________________________________

IF YOU HAVE POWER OF ATTORNEY, WE WILL NEED TO HAVE A COPY OF THE LEGAL DOCUMENT FOR OUR RECORDS.