Southwest Naturopathic
Medical Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, acknowledge that I have received a copy of Southwest Naturopathic's Notice of Privacy Practices.

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Patient or legally authorized individual signature | Date

____

Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal Representative, etc.)

I authorize and agree that Southwest Naturopathic Medical Center (SWNMC) may disclose my protected health information to the following persons, each of who is directly involved in my care:

1.______________________________ 2.______________________________

3.______________________________ 4.______________________________

I acknowledge and agree that SWNMC may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to SWNMC.

____

Patient or legally authorized individual signature | Date

____

Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal Representative, etc.)

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):

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