

## NOTICE OF PRIVACY PRACTICES

### Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the “Notice of Privacy Practices” of Camino Health Center. Our “Notice of Privacy Practices” tells you how we may use and disclose your protected health information. We encourage you to read it in full.

We may change our “Notice of Privacy Practices.” If we change our notice, you may obtain a copy of the revised notice by contacting our organization at (949) 240-2272, Medical Records.

If you have any questions about our “Notice of Privacy Practices” please contact:

Privacy Officer  
Camino Health Center  
30300 Camino Capistrano  
San Juan Capistrano, CA 92675  
(949) 240-2030

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I acknowledge receipt of the “Notice of Privacy Practices” of Camino Health Center.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(*patient/legal representative*)

If signed by someone other than patient, indicate relationship: \_\_\_\_\_

Print name: \_\_\_\_\_  
(*legal representative*)

(over)

### Inability to Obtain Acknowledgement

Complete only if no signature is obtained. If it is not possible to obtain the individual's Acknowledgment, describe the good faith efforts made to obtain the individual's Acknowledgment, and the reasons why the Acknowledgment was not obtained.

Patient Name: \_\_\_\_\_

Reasons why the acknowledgment was not obtained:

- Patient refused to sign this Acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.
- Other: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(*provider representative*)

Print name: \_\_\_\_\_  
(*provider representative*)