SCNM SOUTHWEST COLLEGE OF NATUROPATHIC MEDICINE & HEALTH SCIENCES
MEDICAL CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of SCNM Medical Center's Notice of Privacy Practices.

Print Patient Name	MR Number (Office Use Only)
Patient or legally authorized individual signature	Date
Printed legally authorized individual signature	Relationship (self, parent, legal guardian, personal representative, etc.)

I authorize and agree that SCNM Medical Center 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 SCNM Medical Center 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 SCNM Medical Center.

Print Patient Name	MR Number (Office Use Only)
Patient or legally authorized individual signature	Date
Printed legally authorized individual signature	Relationship (self, 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):

_____