SONORAN UNIVERSITY OF HEALTH SCIENCES | Clinical Care

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of Sonoran University Clinical Care (Sonoran University Medical Center, Neil Riordan Center for Regenerative Medicine & Sonoran University Community Clinics) Notice of Privacy Practices.

PATIENT NAME (printed)

SIGNATURE: Patient or legally authorized individual

DATE:

PRINT NAME: Patient or legally authorized individual

RELATIONSHIP: (self, parent, legal guardian, personal representative, etc.)

I authorize and agree that Sonoran University Clinical Care (Sonoran University Medical Center, Neil Riordan Center for Regenerative Medicine & Sonoran University Community Clinics) may disclose my protected health information to the following persons, each of whom is directly involved in my care:

1. Print Name — Contact Information

2. Print Name — Contact Information

3. Print Name — Contact Information

I acknowledge and agree that Sonoran University Clinical Care (Sonoran University Medical Center, Neil Riordan Center for Regenerative Medicine & Sonoran University Community Clinics) may disclose my protected health information to the persons identified in this Acknowledgement unless and until I object in writing to such disclosures.

PATIENT NAME (printed)

SIGNATURE: Patient or legally authorized individual

DATE:

PRINT NAME: Patient or legally authorized individual

RELATIONSHIP: (self, parent, legal guardian, personal representative, etc.)

For Office Use Only

We have attempted to obtain written acknowledgement of receipt of Sonoran University Clinical Care Notice of Privacy Practices, but have been unable to do so to date, **because *(please specify)*:** _____