SIMON DIRECT
PRIMARY CARE
DEDICATED TO HEALTH. COMMITTED TO CARE.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I have been given a copy of Simon Direct Primary Care's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Simon Direct Primary Care has the right to change this Notice at any time.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Simon Direct Primary Care Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

_____
_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the Acknowledgement: _____
_____

Completed by: _____ _____

Signature of Simon Direct Primary Care Representative *Date*

_____

Print Name