

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print name) \_\_\_\_\_ have been presented a copy of Mayfield Clinic's Notice of Privacy Practices, detailing how my health information may be used and disclosed under federal and state laws.

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*Please mail completed form to: Mayfield Clinic, Attn: Initial Care Department, 506 Oak Street, Cincinnati, OH 45219.  
Please note this is our business office address. Call 513.221.1100 if you need addresses for appointments or film drop off.*

*If you are signing as a legal representative for an individual, read and complete the form below:*

I, \_\_\_\_\_, hereby certify and attest that I am the duly authorized legal representative of \_\_\_\_\_ and that I have the lawful authority regarding the use and/or disclosure of Protected Health Information of such individual for the purposes set forth in this document.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name \_\_\_\_\_

**FOR INTERNAL USE ONLY**

Name \_\_\_\_\_

MRN \_\_\_\_\_

If, after good faith efforts, written acknowledgment has not been obtained, document below the good faith efforts which were used to obtain such acknowledgment and the reason why the acknowledgment was not obtained (give dates and times as appropriate).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_