ROGUE RIVER
FAMILY PRACTICE CLINIC

509 E. Main Street
Rogue River, Oregon 97537
www.rogueriverfpc.com
541-582-0505

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________ (print patient name), acknowledge and agree that I have received a copy of Rogue River Family Practice Clinic's Notice of Privacy Practices.

Patient signature ______________________________ Date ______________

Patient legal representative signature ______________________________ Date ______________

Print name of legal representative ______________________________

Relationship to patient ______________________________

FOR CLINIC USE ONLY

Rogue River Family Practice Clinic made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

______________________________ Date ______________

______________________________ Date ______________

______________________________ Date ______________

______________________________ Date ______________

______________________________ Date ______________