



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understand the Metabolic Center for Wellness, P.A., **Notice of Privacy Practices** containing a description of the uses and disclosures of my health information. I further understand that Metabolic Center for Wellness, P.A., may update its **Notice of Privacy Practices** at any time and that I may receive an updated copy by submitting a request in writing.

Patient

Name (printed) _____

Signature _____ Date _____

Patient's personal representative (if applicable)

Name (printed) _____ Relationship _____

Signature _____ Date _____

FOR OFFICE USE ONLY

Complete this form if unable to obtain signature of patient or patient's personal representative.

Metabolic Center for Wellness, P.A., made a good-faith effort to obtain the patient's written acknowledgment of the **Notice of Privacy Practices**, but was unable to do so because the patient or patient's personal representative—

- Refused to sign
- Was unable to sign
- Other

Employee

Name (printed) _____

Signature _____ Date _____