Adventist HealthCare
Adventist Medical Group

Acknowledgement of Privacy Practices

Patient Name: ______________________ Medical Record Number: ______________________

Date: __________

I acknowledge I was given Adventist HealthCare Adventist Medical Group's Notice of Privacy Practices today.

Patient Signature: ____

Witnessed by: ______________________

Adventist Medical Group Staff Member Name: ______________________________

Title: ______________________

If patient declines to sign, Adventist Medical Group staff member signs below to confirm that Notice was offered to patient on the date listed above and patient declined to sign acknowledgement.

Adventist Medical Group Staff Member Name: ______________________________

Title: ____