RIVERSIDE MEDICAL CLINIC

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____

MR#: _____

The Riverside Medical Clinic *Notice of Privacy Practices* provides detailed information about how we may use and disclose your protected health information. It also describes your right to request restrictions on how we use and disclose this information. You are being given a copy of the *Notice of Privacy Practices* at this time and we encourage you to read it carefully.

Our *Notice of Privacy Practices* is also available for viewing on the RMC website at www.RiversideMedicalClinic.com.

We may change our "Notice of Privacy Practices". If we change our notice, you may obtain a copy of the revised notice by contacting our Customer Relations Department at: (951) 782-5102 or (951) 697-5477 or (951) 782-3602.

By signing below, I acknowledge that I have been given a copy of the Riverside Medical Clinic *Notice of Privacy Practices.*

Signature: _____ Date: _____

(Patient/Parent/Conservator/Guardian)

For RMC Staff – Use Only if Unable to Obtain acknowledgment

Complete only if no signature is obtained. If it is not possible to obtain the individual's Acknowledgment, describe the good faith efforts made to obtain the individual's Acknowledgment, and the reasons why the Acknowledgment was not obtained.

Reasons why the acknowledgment was not obtained:

☐ Patient refused to sign this Acknowledgment even though the patient was presented the Notice of Privacy Practices.

☐ Other: _____

Signature: _____ Date: _____ Time: _____

Print/Type Name: _____