San Dimas Family Practice
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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have received and have read or will read the San Dimas Family Practice – "Notice of Privacy Practices", containing a complete description of the uses and disclosures or my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact them at any time to obtain a current copy.

I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Signature: Date:

Patient's Guardian's Name: Relationship to Patient:

I attempted to obtain the patient's signature on this "Acknowledgement of Notice of Privacy Practices", but was unable to do so as documented below:

Reason:____

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Date: Employee Signature: