Integrated Health Care Providers

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PLACE
PATIENT IDENTIFICATION LABEL
HERE

I have received a copy of the Notice of Privacy Practices and attached Notice of Organized Health Care Arrangement, which lists the entities who join Integrated Health Care Providers, Inc. ("IHCPI") in providing the Notice of Privacy Practices. The Notice describes how health information created or obtained in connection with my medical care at IHCPI will be used or disclosed. I understand that I should read it carefully. I am aware that IHCPI may change its privacy practices and these two Notices and that the changes will apply to all records maintained at IHCPI. If there are changes, I may obtain revised copies of both Notices by calling the Privacy Office at (304) 388-1187 or by requesting copies from any registration department. I can also read the Notice of Privacy Practices on-line by accessing IHCPI's website at www.camc.org.

(Date) ______________________ (Signature) ______________________

(Print or Type Name) ______________________

As the representative of the above-named individual, I acknowledge receipt of the Notices on his or her behalf.

(Date) ______________________ (Signature) ______________________

(Nature of Relationship) ______________________ (Print or Type Name) ______________________

The patient or the patient's representative was given copies of the Notices, but failed or refused to sign this acknowledgment.

(Date) ______________________ (Signature of staff) ______________________

(Reason for failure to sign) ______________________

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