TRINITY COMMUNITY CARE

Acknowledgement of Privacy Practices

We ask that you sign this acknowledgement that you received our Notice of Privacy Practices. However, your care will not depend on signing the acknowledgement and we will continue to provide your treatment and will use and disclose your health information as necessary within the provisions of this Notice.

My signature below constitutes my acknowledgement that I have been given the Trinity Community Care Notice of Privacy Practices to review and that I have been offered and received a copy if I so desire.

Date _____ Print Patient's Name _____

Signature of Patient (or Responsible Consenting Party) _____ Relationship to Patient _____

Signature of Witness _____

Office Use Only:

Patient was offered and refused to sign acknowledgement.

Date _____ Print Patient's Name _____

Signature of Clinic Volunteer _____