GENERATIONS
Radiotherapy & Oncology PC
at Shelby Baptist Medical Center

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish. I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

____The patient refused to sign
____Due to an emergency situation it was not possible to obtain
____We were not able to communicate with the patient
____Other (provide detail)_____

Employee Signature _____ Date _____