ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Advanced Urgent Care Center reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy to the patient in the clinic. I may request a copy of the updated Notice of Privacy Practices by calling the clinic or requesting a copy in person at my appointment.

Patient's Printed Name	Date of Birth
Patient/Legal Representative Signature	Date
Relationship to Patient	
Witness	Date

The following names are of people I would like to be involved in or have access to my protected health information on routine basis. I give permission for Advanced Urgent Care Center to share my protected health information with:

Name	Relationship
Name	Relationship
Name	Relationship