

**METHODIST SPORTS MEDICINE CENTER**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM**

By signing below, I hereby acknowledge the receipt of METHODIST SPORTS MEDICINE CENTER'S Notice of Privacy Practices.

PRINT NAME

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Good Faith Effort was used to obtain acknowledgment, despite this effort

\_\_\_\_\_ Patient Refused

\_\_\_\_\_ Patient Unable due to \_\_\_\_\_.

Staff member's signature and date \_\_\_\_\_.

signature

date