MONROE CITY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

**Acknowledgement of Notice of Privacy Practices**

I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Clarity Healthcare.

| Patient Signature: | Date: |
|---|---|
| | |

If this acknowledgement is being signed by a personal representative on behalf of the patient, complete the following:

| Name: | Relationship to patient: |
|---|---|
| | |

If you would like a copy of this acknowledgement, please initial: _____Yes _____No Witness Initials: ____

*This form will be retained as part of your medical record.*

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement above, but acknowledgement could not be obtained because:

_____ Individual refused to sign acknowledgement

_____ Communication barriers prohibited the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other, please specify: ______________________________________________________________

| Employee name: | Date: |
|---|---|
| | |