GEARY COMMUNITY HOSPITAL
RURAL HEALTH CLINIC
NOTICE OF PRIVACY PRACTICES

Patient Name (print): _____ Date of Birth: _____

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date to acknowledge that you have received both layers of this Notice of Privacy Practices. Then detach this acknowledgement and return it to the receptionist.

Patient Signature: _____

Patient Name (print): _____

Date: _____

If patient is unable to sign, please complete the following:

Signature - Authorized Person: _____

Printed Name - Authorized Person: _____

Relationship toPatient: _____ Date: _____