Date of Birth: _____

Medical Record Number: _____

Account/Financial ID Number: _____

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient or Patient's Representative

_____

Printed Name of Patient's Representative (if applicable)

_____

Representative's Relationship to Patient (if applicable)

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After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason:

_____

_____

_____

_____ _____

Signature of USA Health Representative Date

The effective date of this notice is January 1, 2019.