

# Smith Clinic/Marion Area Health Center

## Acknowledgement of Receipt of Notice of Privacy Practices

**This is to acknowledge that Smith Clinic/Marion Area Health Center's  
Notice of Privacy Practices (effective date April 14, 2003)  
has been made available to me on the date stated below.**

\_\_\_\_\_  
Date of Patient/Personal Representative's  
Signature

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Please Print Patient's Name

Patient's Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
City/State/Zip

If applicable, Name of Personal Representative: \_\_\_\_\_

If applicable, Description of Representative's  
Authority to act for the Patient: \_\_\_\_\_