PHYSICIANS' ALLIANCE LTD.
Notice Version: 10/14/13

MRN: _____

Patient name: _____**Date of Birth**:___/___/___
(Please Print)

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices for Physicians' Alliance Ltd.

Patient Signature:_____ **Date**:___/___/___

or

Patient's personal representative with legal authority to make health care decisions on the patient's behalf.

_____ _____
Personal Representative's Printed Name **Relationship to Patient**

Personal Representative's Signature:_____ **Date**:___/___/___

OFFICE USE ONLY:
If this form is not signed by the patient, or personal representative, complete the following:

The Notice of Privacy Practices was given to the patient or their personal representative on_____ by _____.

The following good faith efforts were made to obtain the signature of the patient, or personal representative: _____
_____.

Reason Patient or Personal Representative did not sign this form: _____
_____.

Signature:_____ **Date**:___/___/___

Print Name:_____ **Title**:_____