Medical Record Number _____

Notice of Health Information Practices Sign-Off Form

By my signature below, I acknowledge that:

1. I have received a copy of the *Notice Of Health Information Practices* (3 pages).
2. I have read, or have had read to me, the entire *Notice Of Health Information Practices* which:
   a. States the normal uses and disclosures of patient information.
   b. Outlines Creekmore Clinic's responsibilities under the HIPPA Privacy Rule.
   c. Details my rights as a patient or legal representative of a patient.

The original of this *Notice of Health Information Practices Sign-Off Form* will be retained with my medical record and a copy will be made for my records.

X _____ _____

Signature of Patient or Legal Representative — Date and Time

_____

Print Patient's Name

_____ _____

Print Name of Legal Representative (if applicable) — Relationship to Patient

_____ Patient's Initials