



**Acknowledgement of Receipt of
Notice of Privacy Practices**

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Mansfield Urgent Care reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy to the patient in the clinic. I may request a copy of the updated Notice of Privacy Practices by calling the clinic or requesting a copy in person at my appointment.

Patient's Printed Name

Date of Birth

Patient/Legal Representative Signature

Date

Relationship to Patient

Witness

Date

The following names are of people I would like to be involved in or have access to my protected health information on routine basis. I give permission for Mansfield Urgent Care to share my protected health information with:

Name

Relationship

Name

Relationship

Name

Relationship

