Acknowledgement of Receipt of Notice of Privacy Practices

Timothy A. Murphy, M.D. – *Privacy Officer*
577 East Elder Street, Ste. C, Fallbrook, CA 92028
(760) 723-5459

I hereby acknowledge that I have seen/received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- ☐ I would like to receive a copy of any amended Notice of Privacy Practices by mail at my home address: _____
  _____

- ☐ I do not wish to receive a copy of any amended Notice of Privacy Practices by mail at my home address.

Name of Patient: _____

Sign: _____ _____
(Print Name of Signator)

Date: _____

Phone: _____

If not signed by the patient, please complete the following:

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient