ROSENBERG COOLEY METCALF
THE ORTHOPEDIC CLINIC AT PARK CITY

ACKNOWLEDGMENT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of The ROSENBERG COOLEY METCALF CLINIC'S Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about The ROSENBERG COOLEY METCALF CLINIC'S privacy practices or my rights with regard to my personal health information, I may contact the appropriate person for further information as set forth in the Notice.

_____ _____
Name of Patient (and Patient's Representative, if one) **Patient Identification #**

_____ _____
Signature of Patient (or Patient's Representative) **Date**

Staff Use Only:
To Be Used By Office Staff Only If Patient Written Acknowledgement Is Not Obtained.

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ **Patient Identification #:** _____

I hereby certify that on ___/___/___ (MM/DD/YR), I made a good faith effort to obtain the above patient's written acknowledgement of receipt of The ROSENBERG COOLEY METCALF CLINIC'S Notice of Privacy Practices, but I was unable to do so for the following reason(s);

_____

_____

_____
Name of Staff Person (Type or print)

_____ **Date:** _____
Signature of Staff Person

1820 Sidewinder Drive / Park City, UT 84060 / Telephone (435)655-6600 / Fax (435)655-2388