

ACKNOWLEDGEMENT OF RECEIPT OF POHCA JOINT NOTICE OF PRIVACY PRACTICES

By my signature below, I hereby acknowledge that I have either received or have been offered a copy of the Providence Organized Healthcare Arrangement (POHCA) Joint Notice of Privacy Practices.

Patient Name (Printed)

Patient (or Authorized) Signature

Date

If Authorized Signature, Relationship to Patient

INSERT PATIENT LABEL IF AVAILABLE

<u>Patient Information:</u>		
NAME:		
PHYSICIAN:		
ADM. DATE:		
D.O.B.:	AGE:	SEX:

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PROVIDENCE CLINICS
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