Riverside MEDICAL GROUP

Your family's complete medical home.

NOTICE OF PRIVACY PRACTICES RECEIPT RIVERSIDE MEDICAL GROUP

I, _____ acknowledge receiving the Riverside Medical Group Notice of Privacy Practices. I also acknowledge that future revisions of this notice will be available on the Riverside website www.riversidemedgroup.com or upon request.

This pertains to the **HIPAA – NOTICE OF PRIVACY ACT GUIDELINES.** I have received the privacy act guidelines pamphlet and listed all family members who can actively participate in my care planning. I understand that if I do not list these individuals; my patient information or the planning of my care will not be released or planned without my consent.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

_____

Patient or Legal Guardian Signature

Date: _____

_____

Riverside Witness Name _____ Date _____

Revised 01/02/19