VALLEY HEALTH TEAM
LIVE BETTER. VIVE MEJOR.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Valley Health Team, Inc.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

_____ _____
Relationship to Patient Print Name

Source of Authority: _____