

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have read the Notice of Privacy Practices literature regarding the use of my medical information and have been provided with a copy of Malik E. McKany's Notice of Privacy Practices upon my request. **This acknowledgement is valid for one year from the date signed.**

Patient Signature

Date

Witness Signature

Date

My medical information may be discussed with:

Name

Relationship

Phone No.

Name

Relationship

Phone No.

Name

Relationship

Phone No.

Name

Relationship

Phone No.

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT

On (date)_____, the office of Malik E. McKany, MD presented the Acknowledgement of Receipt of Notice of Privacy Practices form to _____ (the patient). The patient refused to provide a signature when requested.