River Horse Medical Clinic, PLLC
Jennifer Grinage, PA-C
Secure Fax: 208-616-1453

Acknowledgment of Receipt of
NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth_____ MR#: _____

I acknowledge that I have received (or have been offered and declined) a copy of River Horse Medical Clinic's Notice of Privacy Practices.

The Notice of Privacy Practices provides information about my rights related to my protected health information and how my protected health information may be used or disclosed.

I understand that I have the right to review this notice prior to signing this acknowledgement.

I understand that River Horse Medical Clinic reserves the right to change this notice in accordance with state and federal guidelines.

Signature of Patient/Guardian/Legal Representative: _____Date: _____

Printed Name: _____Relation to Patient: _____

Witness Initials: _____Witness Name: _____Date: _____

----------For Internal Clinic Use----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ Patient/Guardian/Legal Representative Refused to Sign

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Telehealth visit, patient sent NOPP.

River Horse Medical Clinic Representative: _____ Date: _____