FAMILY MEDICAL CENTER
Rocky Mount

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been provided a copy of Rocky Mount Family Medical Center's Notice of Privacy Practices that informs me of uses, disclosures, and rights pertaining to my protected health information.

I acknowledge receipt of a copy of Rocky Mount Family Medical Center's Notice of Privacy Practices.

_____ _____
Patient / Guardian / Guarantor Signature Date

_____
Please Print Name

_____ _____
Witness Date