



**NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS & RESPONSIBILITIES  
ACKNOWLEDGEMENT RECEIPT**

Name of Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

Last four numbers of your Social Security: \_\_\_\_\_

I acknowledge that I have been given a copy of **PHOENICIAN MEDICAL'S**

Notice of Privacy Practices and Patient Rights & responsibilities. I also know I can go to [evfm.care](http://evfm.care) and read the documents.

\_\_\_\_\_  
Signature of Patient (or Personal Representative/Guardian)                      Date

I acknowledge that I declined a copy of **PHOENICIAN MEDICAL'S** Notice of Privacy Practices and Patient Rights & Responsibilities..

\_\_\_\_\_  
Signature of Patient (or Personal Representative/Guardian)                      Date