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**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE**

I hereby acknowledge that I have received a copy of Frederick Memorial Healthcare Systems' Notice of Privacy Practices. I have also received a copy of Oncology Care Consultants' Medical Record Policy.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

If not signed by the patient, please indicate:

**Relationship:**

- \_\_\_\_\_ Parent or guardian of minor patient
- \_\_\_\_\_ Guardian or conservator of an incompetent patient
- \_\_\_\_\_ Beneficiary or personal representative of deceased patient

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

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***For Office Use Only:***

\_\_\_\_\_ Signed form received by: \_\_\_\_\_

\_\_\_\_\_ Acknowledgement refused: \_\_\_\_\_

Efforts to obtain: \_\_\_\_\_  
\_\_\_\_\_

Reasons for refusal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Staff Signature:** \_\_\_\_\_