

# **Premier Medical Clinic**

315 East Ash Street  
Perry, Florida 32347

## **Acknowledgment of Notice of Privacy Practices**

I, \_\_\_\_\_ acknowledge receipt of the currently effective Notice of Privacy Practices from Premier Medical Clinic this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_. I have reviewed the information and am aware of my rights as they are outlined in the document.

I understand that if I feel that my privacy protection rights have been violated, that I may submit a formal, written complaint to the Department of Health and Human Services, Office of Civil Rights, without fear of retaliation by Premier Medical Clinic.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

(Power of Attorney or Judicial Order attached for Authorized Representative Signature)