Patient Name: ___________________________

DOB: _________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Rocky Mountain Cancer Centers is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

❑ I acknowledge that I have received a copy of the Notice of Privacy Practices

❑ I decline a copy of the Notice of Privacy Practices

______________________________	______________
Patient Name or Personal Representative (Please print)	**Patient's Date of Birth**

______________________	______________________	______________
Signature of Patient or Personal Representative	**Relationship to Patient (If patient not signing)**	**Date**

(Use by Rocky Mountain Cancer Centers only)

Date acknowledgement received: ___________________________

-OR-

Reason acknowledgement was not obtained:

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Rocky Mountain Cancer Centers complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 303-930-7880 (TTY: 711).

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