ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that the Notice of Privacy Practices for Plaquemines Medical Center, which describes how health information about myself may be used or disclosed and how I can obtain access to this information is available for viewing and if requested, a copy of the practices will be provided.

________________________________	________________________________
Patient/Guardian Signature	Witness
________________________________	________________________________
Print Name of Patient	Patient's Date of Birth
________________________________	________________________________
Date of Signature	Date

FOR OFFICE USE ONLY:

Documentation of Failure to Obtain Signed Acknowledgement:

On _______________________________________, this Acknowledgement of Notice of Privacy Practices was presented to __________________________________ (the Patient/Guardian). The Patient /Guardian refused to provide a signature when requested.

Privacy Officer :
Leslie R. Prest, Administrator
27136 Hwy. 23
Port Sulphur, LA 70083
(504) 564-3344

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