SOUTH BAY TOTAL HEALTH

Please fill out and return

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that South Bay Total Health has provided me with a copy of its **Notice of Privacy Practices** that describes how medical information about me may be used and disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact:

Arlan Cage, ND, MSOM, MS • 310-803-8803

I also understand that I am entitled to receive updates upon request if South Bay Total Health amends or changes its **Notice of Privacy Practices** in a material way.

_____ _____

Signature Relationship to Patient
if signed by someone other than patient

_____

Date

THIS SECTION IS TO BE COMPLETED BY SOUTH BAY TOTAL HEALTH
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named client, but was unable to because:

☐ Client declined to sign this Written Acknowledgment.

☐ Other (specify): _____

_____ _____

Name and title of employee Date