



Acknowledgement of Receipt of Notice

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|--|---|---|---|
| <input type="checkbox"/> MCC – Larkspur
5 Bon Air Road, Bldg G, Ste 117
Larkspur, CA 94939
Fax: 415-461-7334 | <input type="checkbox"/> MCC – Novato North
6100 Redwood Blvd.
Novato, CA 94945
Fax: 415-798-3198 | <input type="checkbox"/> MCC – San Rafael
3110 Kerner Blvd.
San Rafael, CA 94901
Fax: 415-526-8553 | <input type="checkbox"/> MCC – Campus
3260 Kerner Blvd.
San Rafael, CA 94901
Fax: 415-755-2550 |
| | <input type="checkbox"/> MCC – Novato South
6090 Redwood Blvd.
Novato, CA 94945
Fax: 415-798-3198 | <input type="checkbox"/> MCC – San Rafael Dental
3110 Kerner Blvd.
San Rafael, CA 94901
Fax: 415-526-8556 | <input type="checkbox"/> MCC – Dental
San Rafael
411 4 th Street, Ste A & C
San Rafael, CA 94901
Fax: 415-526-8556 |
| | <input type="checkbox"/> MCC –Novato Dental
6090 Redwood Blvd.
Novato, CA 94945
Fax: 415-798-3198 | | |

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No → I would like to receive a copy of any amended Notice of Privacy Practices:

By e-mail at: _____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgment refused:

Efforts to obtain:

Reasons for refusal:

