445 St. Paul Street
Tel: (401)-597-5665 North Smithfield, RI 02896 Fax: (401)-597-5667

ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of Matrix Sports Medicine and Physical Therapy, Inc. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Matrix Sports Medicine & Physical Therapy, Inc. In addition, I have been advised of how I may obtain access to and control this information.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____
Date

This section will be completed if the written acknowledgement is not obtained.)

We have made a good faith effort to obtain an individual's acknowledgement, however, the acknowledgement was not obtained for the following reason(s):

□ The individual refuses to sign or otherwise fails to provide acknowledgment.

□ The individual was mailed a copy of the Notice and did not mail back his or her receipt of acknowledgement.

□ Other: _____

Completed By: _____

Date: _____