HEIGHTENED HEALTH FUNCTIONAL FAMILY MEDICINE CENTER
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to undersigned patient ("Patient"):

Heightened Health, S.C., an Illinois professional corporation dba Heightened Health Functional Family Medicine Center ("Practice"), is required to provide Patient with a copy of Practice's Notice of Privacy Practices ("Notice"), which states how Practice may use and/or disclose Patient's health information.

Please sign this form to acknowledge receipt of the Notice.
You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of Practice's Notice of Privacy Practices.

Patient's name (please print): _____
Signature: _____
Date: _____

FOR OFFICE USE ONLY

Practice made every effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices from Patient but it could not be obtained because:

Patient refused to sign.

Due to an emergency, it was impossible to obtain an acknowledgment.

Practice was unable to communicate with Patient.

Other: _____
_____
_____