WEST TENNESSEE HEALTHCARE CLINICS

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of The Clinic's Joint Notice of Privacy Practices.

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Name (Print)

____ ____________________
Signature (Relation, if other than patient) Date

☐ Patient unable to sign/ No family available

☐ Patient refused to sign

☐ Other: ____

☐ Employee Signature: ____

The Clinic's Use Only (Do not write below this line)

Date acknowledgment mailed: ________________________

Date acknowledgment received: ________________________

Advanced Directives:

Do you have a living will or durable power of attorney? ☐ No ☐ Yes

If you do have a durable power of attorney, please identify: ________________________________

Would you like us to give you a packet of information regarding advance directives:

☐ No ☐ Yes (Packet distributed)

________________________________ ____________________
Patient Signature Date

________________________________ ____________________
Witness Date