



INTERMOUNTAIN
IMMC
MEDICAL CLINIC™

Our specialty is you

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, (patient name and DOB) _____, (____/____/____)
have been informed of the Privacy Practice Notice of the above organization.

I am aware a written copy is available to me upon request.

I request a copy of the Notice of Privacy Practice. (*Please mark here if you would like to receive a copy of the Privacy Notice.*)

Signature of Patient or Legal Guardian

(____/____/____)
Date