"An Employee Owned Company"

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Ivyland, PA 18974
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email: medical@delcrest.com
Phone: 800-672-8400
Fax: 215-675-1128

Name: ____

Acknowledgement

I certify that I received a copy of this Delcrest Medical Services, Inc. *Privacy Notice* and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting my health information.

Date:___________ My Signature: ________________________________

My Printed Name: ________________________________

Date:___________ Signature of Witness: ____________________________

-OR-

I certify that I am the authorized representative of ____________________________, and that I have received Delcrest Medical Services *Privacy Notice* on behalf of this individual and that the facility provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting health information.

Date:_____________ Signature of Representative: ____________________________

Printed Name: ____________________________

Relationship to Individual: ____________________________

Date:_____________ Signature of Witness: ____________________________

A copy of the *Privacy Notice* was provided and this document must be filed in the medical record.