

**Ronnie Mitchell, D.O., P.A.**  
**Family Medicine**

**Acknowledgement of Receipt of Notice of Privacy Practices**

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Ronnie Mitchell, D.O., P.A. which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

\_\_\_\_\_  
Signature of the Patient/Patient's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

**For Official Use Only**

I, \_\_\_\_\_, made a good faith effort to obtain written acknowledgement of \_\_\_\_\_'s receipt of the Notice of Privacy Practices of Ronnie Mitchell, D.O., P.A. However, I could not obtain written acknowledgement because:

Individual refused to sign this Acknowledgement

Communications barrier prohibited obtaining written acknowledgement

An emergency situation prevented obtaining written acknowledgement

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_