MEMORIAL HEALTH SYSTEM, INC.
ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I have been presented with and received the Notice of Privacy Practices for Memorial Health System, Inc.

I understand that this Notice of Privacy Practice may change over time and that the obligations of Memorial Health System, Inc. and my rights under it may change.

Name of Patient	Signature of Patient	Date
Guardian of Patient	Signature of Guardian	Date
Witness	Signature of Witness	Date

Patient or guardian of patient refused to acknowledge receipt of the Notice of Privacy Practices of Memorial Health System, Inc.

Witness	Signature of Witness	Date

Acknowledgment of receipt of the Notice of Privacy Practices was not obtained, despite Memorial Health System, Inc.'s good faith efforts, because

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Witness	Signature of Witness	Date