MOUNTAIN VIEW REHABILITATION MEDICAL ASSOCIATES, INC.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Mountain View Rehabilitation Medical Associates, Inc.'s Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed name of Patient or legal Guardian

_____

Patient name (if the above is NOT the patient's signature)

IF YOU DO NOT INTEND TO KEEP A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR YOUR PERSONAL RECORDS, PLEASE RETURN IT TO THE OFFICE STAFF. YOU MAY REQUEST ANOTHER COPY AT ANY TIME. THANK YOU.