Hands on Healthcare, Inc.

3440 Kingston Rd.
York, PA 17402

Phone (717)332-4377
Fax: (717) 840-1787

RECEIPT OF NOTICE OF HIPPA PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

Regulations require that we make a "Good Faith" effort to provide you with a copy of our Privacy Notice. You are not required to accept the notice.

I acknowledge that I received or had the opportunity to review "The Notice of Privacy Practices" for Hands on HealthCare, Inc.

_____
Print Patient Name

_____ _____
Patient Signature Date

_____ _____
Personal Representative (if applicable) Relationship to Patient

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Provide the name and relationship of the person(s) with whom we may share patient information (medical, billing, and appointments) about you. This information will expire only when requested by the patient. If your Primary Care Physician is other than your referring physician, you will need to list him/her her in order for them to receive reports about your care.
PLEASE PRINT

_____ _____

_____ _____

_____ _____

_____ _____
Patient Signature Date