MyCare Health Center

18 Market Street, Suite C, Mt. Clemens, MI 48043	P: 586.783.2222	F: 586.783.6280
6900 E. Ten Mile Road, Center Line, MI 48015	P: 586.756.7777	F: 586.756.7788
42627 Garfield, Suite 213, Clinton Township, MI 48038	P: 586.783.3904	F: 586.783.3906
43740 Groesbeck Highway, Clinton Township, MI 48036	P: 586.493.0961	F: 586.493.1001

www.mycarehealthcenter.org

Acknowledgement of Receipt of Privacy Information Practices

My signature on this form indicates that I have received a Notice of Privacy Information Practices. I also acknowledge that I am aware the Privacy Information Practices are located on the web site above and in the clinic lobby for review.

I the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, who will be able to answer my questions.

Privacy Officer
Shari Pierce, Practice Manager
6900 East 10 Mile Rd.
Centerline, MI. 48015
586-756-7777

I request the following restrictions to the use or disclosure of my Protected Health Information. I understand you may or may not agree to my request. I also understand if you agree to the restriction, if the restricted information is needed to provide me with emergency treatment, you may suspend the agreement and provide a health care provider with any needed information.

☐ I do not wish messages left on my voice mail at: _____

☐ I do not wish to be contacted by fax machine.

☐ I do not wish to be contacted by email.

☐ I do not wish to have mail sent to my address on file.

☐ I wish **only** the following person(s) to receive my protected health information.

Name: _____ Relation: _____ Birth Date:_____

Name: _____ Relation: _____ Birth Date:_____

Other: _____

_____
Print Name

_____ Date: _____
Signature of Patient or Legal Representative

Office Use Only:

☐ Accepted restrictions

☐ Denied restrictions