Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices at:

San Carlos Apache Healthcare Corporation
Izee' Baa Gowąh

PO BOX 787, Peridot, AZ 85542

Patient Signature	Date
Signature of Patient Representative (State Relationship to Patient) Or Witness (if signature is by thumb print or mark)	Date
Signature of Patient Registration Employee	Date

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the Notice of Practices Because:

_____

Signature of Patient Registration Staff	Date