Receipt of Notice of Privacy Practices Form

I, _____, acknowledge receipt of The Medical Group of Kankakee
(Name of Patient)
County's notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that The Medical Group of Kankakee County has reserved a right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at me at my next visit to the practice.

Signed: _____Date: _____

If you are not the patient, please specify your relationship to the patient _____.