



Floyd Valley Hospital

Family Medicine Clinic – Le Mars

An Avera Partner

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for Floyd Valley Hospital Family Medicine Clinic.

The privacy brochure can be found in the waiting area and on our website at www.familymedicineclinics.org.

Floyd Valley Hospital Family Medicine Clinic, reserves the right to modify the privacy practices outlined in the notice.

Patient Legal Name (Please Print)

or _____
Guardian Name and Relationship

Patient Signature

or _____
Guardian Signature

Patient Date of Birth

Phone Number

Today's Date

Cell Phone Number

I, (patient name) _____ authorize Floyd Valley Hospital Family Medicine Clinic to release any Protected Health Information regarding myself to the following individuals:

For Office use only: A signature was not obtained because _____

Name of Staff Member: _____