



**DR. GARY BIRDSALL
MEDICAL CLINIC, LLC**

102 W 112th Street, Cut Off, LA 70345 | Phone: 985-632-5222 | Fax: 985-632-4222

Acknowledgement of receipt of notice of privacy practices

I, (name of patient) _____, acknowledge and agree that I have been given an opportunity to read the Dr. Gary Birdsall Medical Clinic, LLC's Notice of Privacy Practices.

Patient Signature

Date

Patient Legal Representative

Date

Print Name of Legal Representative

Relationship to Patient

For Clinic Use Only:

Dr. Gary Birdsall Medical Clinic, LLC made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices. Include date, time, and phone numbers and reason acknowledgement not obtained.