MedicoRx Specialty
& HOME INFUSION PHARMACY
7039 Valjean Avenue, Van Nuys, CA 91406
Ph: **(818) 390-9696** Fax: **(818) 390-9697**
www.medicorx.com

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ File No.: _____

Address: _____

I, _____ (patient's name), have been given a copy of MedicoRx Specilaty Pharmacy's Notice of Privacy Practices (Notice), which describes how my health information is used and/or shared. I understand that MedicoRx Specialty Pharmacy has the right to change this Notice at any time. I may obtain a current copy by contacting MedicoRx Specialty Pharmacy's Privacy Officer, or by visiting the MedicoRx Specialty Pharmacy website at www.medicorx.com.

My signature below acknowledges that I have reviewed or have been offered to review a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Name of Representative's Title

For Facility Use Only: Complete this section if you are unable to obtain signature:

1. If the patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any reason, state the reason:
   _____
   _____
2. Describe steps taken to obtain the patient's (or personal representative's) signature on the Acknowledgement:
   _____
   _____

Completed by:

_____ _____

Signature of Facility Representative Date

_____

Print Name