AGAPE
METROPOLITAN COMMUNITY HEALTH SERVICES, INC.

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the MCHS Notice of Privacy Practices ("Notice"):

- It tells me how Metropolitan will use my health information for the purposes of my treatment, payment for my treatment, and Metropolitan health care operations.
- The Notice explains in more detail how Metropolitan may use and share my health information for other than treatment, payment, and health care operations.
- Metropolitan will also use and share my health information as required/permitted by law.
- If I am an Metropolitan patient receiving health services, I consent to Metropolitan using and disclosing my treatment and education records maintained by OU for the purposes detailed in Metropolitan Notice of Privacy Practices.

Patient's Complete Legal Name: _____

(PLEASE PRINT)

Patient's DOB: _____ /_____ /_____ Date: _____ /_____ /_____

Signature: _____

(*Patient or legal representative)*

*May be requested to show proof of representative status