HIPAA Acknowledgement of Notice

I hereby acknowledge that I have been provided a copy of Haight Ashbury Free Clinics, Inc.'s Notice of Privacy Practices.

Patient Signature: X_____

Print Name: _____

Date: _____

If you wish to obtain a copy of your medical record regarding this visit, please return this form to Haight Ashbury Free Clinics, Inc. in person, mail, or fax:

Haight Ashbury Free Clinics, Inc.
Rock Medicine
ATTN: Privacy Official
P.O. Box 756 Roseville, CA 95661