

**JORDAN LANDING CLINIC, LLC**  
**NOTICE OF PRIVACY ACKNOWLEDGEMENT**

NOTICE OF RECEIPT

By signing this form, you acknowledge having received the  
“Notice of Privacy Practices” for **Jordan Landing Clinic**.

Patient Name \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

Date: \_\_\_\_\_

I hereby authorize **JORDAN LANDING CLINIC, LLC** to release my medical  
information to the following individuals:

\_\_\_\_\_  
\_\_\_\_\_

I give my permission to **JORDAN LANDING CLINIC, LLC** to leave a detailed  
message on my voice mail, or with a family member \_\_\_\_\_.

(Initials)