

MAUREEN MBADIKE-OBIORA, M.D.
Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receipt of the *Notice of Privacy Practices* of Maureen Mbadike-Obiora, M.D.

I understand that this is just an acknowledgement of receipt – it does not obligate me in any way.

Name of Patient: _____

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

IN ABILITY TO OBTAIN ACKNOWLEDGEMENT

Describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

2415 High School Avenue, Suite 300 Concord, CA 94520

Tel: (925) 685-8894 Fax: (925) 609-7558