Miracles Healing Centers, Inc
134 Professional Park Dr. Suite 400
Mooresville, NC 28117
704-664-1009

Acknowledgement of Receipt of
Notice of Privacy Practices

Name:_____ MR#:_____

I understand that Miracles Healing Centers, Inc is a healthcare provider and may share my health information for treatment, payment and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Miracles Incorporated has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at 704-664-1009.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices.

If any person is physically unable to provide a signature OR signs with a mark, print his/her name on the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

If patient/resident is not capable of acknowledging the notice because of age or medical condition, complete the following:

Patient/resident is a minor (__ years of age) OR Patient/resident is unable to acknowledge because _____.

_____

Patient/Legal Guardian/Relative Signature Date Legal Guardian/Relative

_____

Witness Date
Witness

For Miracles Healing Centers, Inc use only
Version given:_____.

Patient/resident/client did not sign due to:_____