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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I certify that I have received a copy of Thrive MD Las Cruces' ("Practice") Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Practice's health care operations. The Notice of Privacy Practices also describes my rights and Practice's duties with respect to my protected health information. The Notice of Privacy Practices is also posted in the office and on Practice's website at <https://thrivemdmc.com/>. Thrive MD Las Cruces reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing Practice's website.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient or Patient Representative