

FAMILY MEDICAL CLINIC

Name of Patient (please print)

Date of Birth

ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES

Version 04012003.01

I hereby acknowledge that I received the Family Medical Clinic's Notice of Privacy Practices.

Signature of patient or patient representative

Date

Documentation of Good Faith Efforts

To obtain patient's acknowledgement that they received provider's
Notice of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient)

The patient presented to the office on _____(date) and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

___ Patient refused to sign.

___ Patient was unable to sign or initial because:

___ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

___ Other reason (describe below):

Signature of Employee Completing Form

Date