

Associates in Family Medicine, P.C.

Name of Patient _____

Patient Date of Birth _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices with the effective date of September 23, 2013.

Signature of Patient/Guardian/Patient Representative

Date

Relationship to Patient

For Practice Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____

Signature of Employee Completing Form: _____