

Acknowledgment of Receipt of Notice of Privacy Practices

This form will be retained with your medical records.



Signed Acknowledgement

By my signature, I acknowledge that I received a copy of the **Notice of Privacy Policy** from OrthoWashington.

Signature of Patient or Representative*: Date:

*If this acknowledgment is signed by a guardian or personal representative on behalf of the patient, please complete the following

Name of Signer:

Relationship to Patient:

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgment of receipt of **Notice of Privacy Practices** but acknowledgment could not be obtained because:

- Patient and/or Personal Representative refused to sign.
- Communication barriers prohibited obtaining the acknowledgment.
- An emergency situation prevented us from obtaining acknowledgment.

Other:

Employee Name: Date: