Western Washington Medical Group

Ear, Nose & Throat, Allergy & Audiology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I,_____, acknowledge that I received a printed copy of the Notice of Privacy Practices for Western Washington Medical Group, **or** I was offered a printed copy of the Notice of Privacy Practices for Western Washington Medical Group and declined receipt.

_____ _____

Signature of Patient (or personal representative) *Date*

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

_____ _____

Personal Representative's Name *Relationship to* Patient

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign
[ ] Communications barriers prohibited obtaining the acknowledgement
[ ] An emergency situation prevented us from obtaining acknowledgement
[ ] Other (Please Specify)

_____

_____

_____ _____

Employee Printed Name *Date*

_____ _____

Employee Signature *Date*

***This form will be retained in your medical record.