Western Washington
Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

_____ _____

Signature of patient (or personal representative) Date

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

Personal Representatives 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
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please specify)_____
_____

_____ _____

Employee Name Date

This form will be retained in your medical record.