Acknowledgement of Receipt of Notice of Privacy Practices

The medical practice of Schlamp Family Medical Clinic, reserves the right to modify the privacy provisions outlined in the notice. We will provide an updated copy of the privacy notice to our patients when changes are made.

I,_____, have received a copy of the Notice Of Privacy Practices for the practice of Schlamp Family Medical Clinic.

_____ _____

Patient Signature Date

_____ _____

Signature of Patient Representative Date

(Required if the patient is a minor or an adult who is unable to sign form)

_____

Relationship of Patient Representative to Patient

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices. The acknowledgement was not obtained because:

_____ The patient was undergoing emergency treatment

_____ The patient declined to sign the acknowledgement

_____ Other:_____

Name of Patient: (Print or Type) _____

Name of Staff Member: _____ Date: _____