Acknowledgment of Receipt of Notice of Privacy Practices

This form with be retained with your medical records.

ORTHOWASHINGTON

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: _____

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