ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Wexford Allergy, Asthma & Immunology LLC's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient:_____
Print Name

_____
Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgment

I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy Practices for protected health information by (check all that apply):

- ❑ Showing the patient the Notice of Privacy Practices posted in our office.
- ❑ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ❑ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ❑ Asking the patient to sign this Acknowledgment form.
- ❑ Other (explain in detail) _____
  _____
  _____

I was unable to obtain the patient's written Acknowledgment because (check all that apply):

- ❑ The patient refused to sign this form.
- ❑ The patient would not sign the form because the patient said he/she did not understand the Notice.
- ❑ Other (explain in detail) _____
  _____
  _____

Date: _____ Name:_____

Notes: This written Acknowledgment must be completed no later than the first date health care services or treatment is provided to the patient. This Acknowledgment must be retained in the patient's permanent records.