Written Acknowledgement of Receipt of Notice of Privacy Practices

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

Patient Type:___________________ **Medical Record Number:**_______________
Patient Name:_____________________________ **Date of Birth:**_______________

Written Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of Day Kimball Medical Group Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact:

Privacy Officer
860-928-6541, extension 2276

____________________________________ ______________________
Signature **Relationship to Patient**

____
Date

TO BE COMPLETED BY STAFF IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE

Patient Type:___________________ **Medical Record Number:**_______________
Patient Name:_____________________________ **Date of Birth:**_______________

On , _____________________________I attempted to obtain a Written Acknowledgement of Receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

( ) Patient declined to sign this Written Acknowledgement

( ) Other (Specify):_________________________________

____ _____________________
Name and title of employee **Date**