WEST MICHIGAN FAMILY MEDICINE

WEST MICHIGAN FAMILY MEDICINE, PC
Acknowledgement of Receipt of Notice of Privacy Practices

By Signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices

Name of Patient Date of Birth

Signature of Patient or personal representative

If signed by personal representative, relationship to patient

Date

Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice Provided to the individual. If written acknowledgement is not obtained, our practice must document Its good faith effort to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

❒ Refused to Sign ❒ Physically Unable to Sign

Other:

Employee Signature:

Date: