CORNERSTONE PEDIATRICS

Notice of Privacy Practices Acknowledgement of Receipt Form

Patient Name: _____ Date of birth: _____

(Please Print)

Personal representative (if applicable): _____

(Please Print)

I hereby acknowledge I have received a copy of the Notice of Privacy Practices for Cornerstone Pediatrics

Patient signature: _____ Today's date: _____

-OR-

Personal representative's signature: _____ Today's date:

TO BE COMPLETED BY MEDICAL FACILITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM THE PATIENT.

On _____, I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to do so because of the following reason(s):

- ☐ Patient (or personal representative) declined to sign the Written Acknowledgement Form.
- ☐ Patient (or personal representative) did not understand the request to sign the Written Acknowledgement Form.
- ☐ Other (specify) _____

  _____

signature: _____ Date: _____