Audiology Center Northwest

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have read this medical practice notice of Privacy Practices.

☐ Yes ☐ No I wish to receive a copy of Notice of Privacy Practices.

Signed: _____ Date: _____

Name: _____ Telephone: _____

If not signed by the patient indicate relationship

☐ Parent or guardian if patient is a minor

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

Name of Patient (if different than above): _____

For office use only:

Signed and received by: _____

Date acknowledgment refused: _____

Efforts to obtain: _____

_____

_____

Reasons for refusal: _____

_____

_____

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