

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Pediatricians of Hyde Park

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Patient Name: _____ Medical Record No. _____

Address: _____

Facility Name: _____

I have been given a copy of Pediatricians of Hyde Park *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that Pediatricians of Hyde Park has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Pediatricians of Hyde Park web site at www.pediatriciansofhydepark.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

Signature

Date

Print Name

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement*:

Completed by:

Signature of Facility Representative

Date

Print Name

File original in resident's Business Office Record.