ColumbiaDoctors

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:_____

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Relationship

For ColumbiaDoctors use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of ColumbiaDoctors Notice of Privacy Practices but was unable to for the following reason:

- □ Patient refused to sign
- □ Patient unable to sign
- □ Other _____

_____ _____

Employee Name Date

This form should be placed in the patient's medical record

Revised March 2014