CHESTERFIELD FAMILY PRACTICE CENTER, P.C.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient's Name _____

I acknowledge receipt of the Notice of Privacy Practices given to me by Chesterfield Family Practice Center.

_____ Date _____

Signature of Patient or Legal Representative

If signed by Representative, Relationship to Patient: _____

☐ Accept ☐ Deny

FOR OFFICE USE ONLY: If patient does not sign above acknowledgement, check reason why acknowledgement could not be obtained:

_____ Patient refused to sign.

_____ Emergency situation.

_____ Other — please explain.

_____

_____

Person seeking acknowledgement: _____

Date: _____