WAYLAND PERSONAL PHYSICIANS, PLLC
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to undersigned patient ("Patient"):

Wayland Personal Physicians, PLLC ("Private Practice"), is required to provide Patient with a copy of Private Practice's Notice of Privacy Practices ("Notice"), which states how Private Practice may use and/or disclose Patient's health information.

Please sign this form to acknowledge receipt of the Notice.

Patient may refuse to sign this acknowledgment, if Patient wishes.

I acknowledge that I have received a copy of Private Practice's Notice of Privacy Practices.

Patient's name (please print): ______________________________

Signature: ____

Date: _____________________

FOR OFFICE USE ONLY

Private Practice made every effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices from Patient but it could not be obtained because:

☐ Patient refused to sign.

☐ Due to an emergency situation, it was not possible to obtain an acknowledgment.

☐ Private Practice was unable to communicate with Patient.

☐ Other: ____

____

____