



## Puget Sound Gastroenterology, PS Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below I, \_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practices for Puget Sound Gastroenterology, PS.

***This form will be retained in your medical record.***

X \_\_\_\_\_  
Signature of client (or personal representative) Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

### For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date