Tamar K. Gottfried, M.D. PLC

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID#:** _______________________

I hereby acknowledge that I have received or reviewed a copy of Tamar Gottfried, PLC's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
Parent or guardian of unemancipated minor
Court appointed guardian
Executor or administrator of decedent's estate
Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____________________________ but acknowledgment could not be obtained because:

Patient/representative refused to sign

Emergency situation prevented us from obtaining acknowledgement at this time
(will attempt again at a later date)

Communication barriers prohibited obtaining acknowledgement (Explain)

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Other (Specify)

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