

Patrick Fitzsimmons, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient ID #: _____

I hereby acknowledge that I have received a copy of Patrick Fitzsimmons, M.D.'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)

- Other (Specify)

