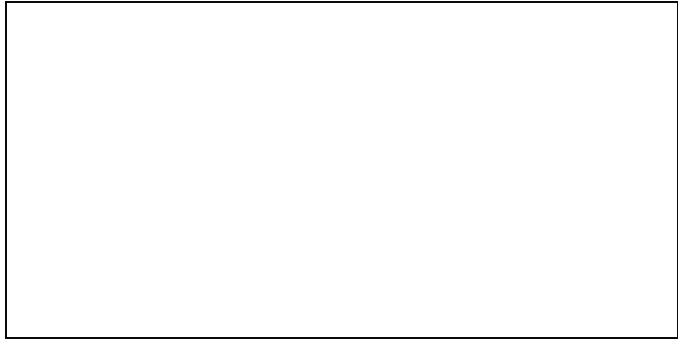




Tufts-New England Medical Center



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Tufts-New England Medical Center and the physician groups listed in this Notice, and how I may obtain access to and control of this information.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Today's Date:

Description/Title of Personal Representative's Authority

Documentation of Good Faith Effort

____ Requested that patient/patient's personal representative acknowledge receipt of Notice of Privacy Practices, but patient/patient's personal representative refused to acknowledge receipt of Notice of Privacy Practices.

____ The Notice of Privacy Practices was mailed to the patient/patient's personal representative at the address of record.

____ Other: _____

Witness

Date

Witness Printed Name:

This form must be delivered to Medical Records Box #999