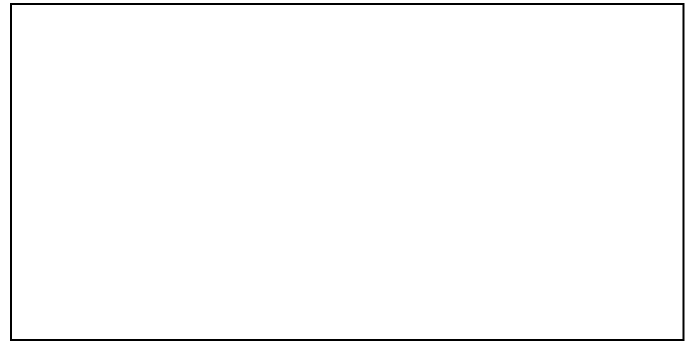

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

<u>Documentation of Good Faith Effort</u>

____ 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