Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I acknowledge receipt of Northwest Physicians Associates, P.C.'s Notice of Privacy Practices

Printed Name of Patient:_____

Signature of Patient:_____Date:_____

If Patient is a Minor, Signature of Parent/ Guardian:_____

If patient is unable to sign, the patient's authorized representative should complete the next section.

By signing this form, I acknowledge that I am authorized to sign this acknowledgement on behalf of _____and that I have received on behalf of the within
Patient Name
named patient a copy of Northwest Physicians Associates, P.C.'s Notice of Privacy Practices.

Signature of Patient's Representative:_____

Printed Name of Patient's Representative:_____

Please Describe Your Authority:

☐ Power of Attorney

☐ Other_____

Witness Signature:_____ Date:_____

Employee use only

If a signature was not obtained from the patient or the patient's representative, please indicate why not:_____

_____

_____

_____

Employee Signature:_____Date:_____

Attention NPA Staff: (Form to be maintained in the patient's medical record with their insurance and demographic information.)