GRANDVILLE PEDIATRICS

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE

I acknowledge that I have received or have been given the opportunity to receive a copy of the HIPPA Notice of Privacy Practices for Grandville Pediatrics.

_____
Patient Name (Please Print)

_____ _____
Patient signature (patient must sign if age 18 or older) Date

_____ _____
Parent/Guardian Name (Please Print) Signature of Parent/Guardian

Authority of Personal Representative to Sign for Patient (check one):

◯Parent ◯Guardian ◯Power of Attorney ◯Other:_____

Please note: It is your right to refuse to sign this Acknowledgment of Receipt

OFFICE STAFF ONLY:
I tried to obtain written Acknowledgement by the Individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained due to one of the following:

◯ An emergency prevented us from obtaining acknowledgement

◯ A communication barrier prevented us from obtaining acknowledgement.

◯ The individual was unwilling to sign.

◯ Other:_____

_____ _____
Staff Member Signature Date