

**CENTER FOR VOICE & SWALLOWING SERVICES, ANDRE L. REED, MD**

**Name of Patient:** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of [insert date].

\_\_\_\_\_  
Signature of Patient/Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

**Documentation of Good Faith Efforts  
To obtain patient's acknowledgment that they received provider's  
Notice of Privacy Practices**

*(For use when acknowledgment cannot be obtained from the patient.)*

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:

\_\_\_\_\_

- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):

\_\_\_\_\_

Signature of Employee Completing Form: \_\_\_\_\_

Date Signed: \_\_\_\_\_