WAYNE STATE UNIVERSITY PHYSICIAN GROUP

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

Our Notice of Privacy Practices gives you information about how we use and disclose medical information about you.

By signing this form, you are acknowledging that you received a copy of our Notice of Privacy Practices.

Name of Patient:_____

If signed by Patient:

Signature:_____

Date:_____

If signed by Personal Representative:

Signature:_____

Printed Name:_____

Relationship to Patient:_____

Date:_____

.....

For internal office use only:

If not signed, reason:

☐ Patient refused to sign ☐ Other:_____

☐ Patient not able to sign (give additional information below regarding disability, emergency situation, etc.)

Comments:

_____

_____

_____

_____

_____ _____

Name of Reviewer Date