



PREventClinic
ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

- I hereby acknowledge that I have received a copy of the PREventClinic Providers' "Notice of Privacy Practices."

 Patient (or Patient Representative) **Signature** Patient Name (**PRINT**) Date Time

 Relationship to Patient Reason Patient is unable to sign Date Time

———— **OR** ————

**CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN
 ACKNOWLEDGMENT**

- hereby certify that, as an employee or agent of the PREventClinic Providers, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the PREventClinic Providers' "Notice of Privacy Practices" in accordance with the policy titled "Provision of the Notice of Privacy Practices."

 Print Name of Employee/Agent and Department

 Signature of Employee/Agent Date Time

Reason(s) For Not Obtaining Acknowledgment: _____

