

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

John A. Schmidt, Jr., M.D. LLC

SECTION A: Patient Information

Name: _____

Address: _____

Date of Birth: _____ Social Security # _____

Section B: Acknowledgement of Receipt of Privacy Policy by Patient or Representative

I, _____, acknowledge that I have received the Privacy Policy from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, please complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Section C: Good Faith Effort to Obtain Acknowledgement of Receipt (to be completed if necessary by Practice Staff).

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign this form: _____

SIGNATURE (to be completed by Patient, Patient Representative, or Practice Staff as appropriate).

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

This acknowledgement form will become part of the Patient's records.