THE POLYCLINIC,
a Washington professional services corporation

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form will be retained in your medical record.

By my signature below I, _____, acknowledge that I **received** a copy of the Notice of Privacy Practices for The Polyclinic.

I hereby designate the following individual(s) to receive communications from the Polyclinic that may include health information about me:

_____

_____ _____
Signature of patient (or personal representative) Date

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

I authorize The Polyclinic to leave voice mail messages concerning my health information (i.e., lab results, appointment instructions, etc.) at the following number:

Phone ( ) _____ (patient initials) _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____

_____

_____ _____
Employee Name Date