Written Acknowledgement Form
Receipt of Notice of Privacy Practices

Date of Implementation 01/01/2018

I acknowledge that I was provided with the Notice of Privacy Practices of Pediatric Associates of Lewiston P.A.

Patient:
DOB:

*Signature of Parent/Legal Guardian_____

Relationship to Child_____

Signature of Witness _____Date: _____

For 18 years of age or older

Signature of Patient _____Date: _____

Patient's DOB:

If the patient refuses to sign this acknowledgement, indicate your attempt to obtain a signature below.

[ ] Patient refused to sign this acknowledgment,
Date: _____
Time: _____

Reason for not obtaining the acknowledgement: _____
Employee Name: _____