BLANCHARD VALLEY MEDICAL ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Birth Date: _____
(Please Print)

By signing below I acknowledge that I have received a copy of Blanchard Valley Medical Associates Notice of Privacy Practices.

X _____ _____
Signature of patient or personal representative Date

_____
If signed by personal representative, relationship to patient

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Office Use Only:

Blanchard Valley Medical Associates has made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices to the individual named below.

Patient Name: _____

Refused to Sign ☐ Physically unable to Sign ☐

Other _____

_____

_____

_____

Employee Signature _____ Date _____