Alyeska Family Medicine
State of the Art Care, Traditional Values

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Alyeska Family Medicine Inc.'s Notice of Privacy Practices.

Signature of Patient/Parent/
Personal Representative: _____

Patient Name: _____ Date: _____
(Please Print)

If not signed by the patient, please indicate the relationship to patient: _____

_____

For Alyeska Family Medicine Inc. Use Only:

☐ Signed Acknowledgement received by: _____

☐ Acknowledgement refused:
Describe good faith efforts to obtain acknowledgement:

_____

_____

Describe reasons why acknowledgement was not obtained:

_____

_____

Employee Signature: _____