

VIJAY PETHKAR M.D., PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient ID #: _____

I hereby acknowledge that I have received a copy of Vijay Pethkar, M.D., PLLC's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Patient or Legal Representative

Date

Printed Name of Patient's Representative (if applicable)

- Relationship to Patient (if applicable)**
- Parent or guardian of unemancipated minor
 - Court appointed guardian
 - Executor or administrator of decedent's estate
 - Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgment could not be obtained because:

- Patient/representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- Communication barriers prohibited obtaining acknowledgement (Explain)

- Other (Specify)

