Village Pediatric Group

CHILDREN'S & WOMEN'S PHYSICIANS OF WESTCHESTER, LLP

ACKNOWLEDGMENT

(OF RECEIPT OF NOTICE OF PRIVACY PRACTICES)

I hereby acknowledge that a copy of ***CHILDREN'S& WOMEN'S PHYSICIANS OF WESTCHESTER, LLP's*** (hereinafter CWPW) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about *CWPW's* privacy practices or my rights with regard to my personal health information, I may contact *CWPW's* Privacy Officer for further information as set forth in the Notice.

Name of Patient - Please Print Name	(Name of Parent or Guardian)
Signature of Patient	Signature of Parent or Guardian
Date	Relationship to patient

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Patient Identification #: _____

I hereby certify that on ____/____/____ I made a good faith effort to obtain the above patient's written acknowledgment of receipt of CWPW's Notice of Privacy Practices, but I was unable to do so for the following reason(s):

Name of Staff Person (Please Print Name)	
Signature of Staff Person	Date

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.