



Privacy Policy Acknowledgement  
Effective Date: September 1<sup>st</sup>, 2019

## Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of Colorado Dermatology Specialists. I hereby acknowledge receipt of Colorado Dermatology Specialists' Notice of Privacy Practices.

Name (please print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OR**

I am a parent or legal guardian of \_\_\_\_\_  
[patient name/date of birth]

I hereby acknowledge receipt of Colorado Dermatology Specialists' Notice of Privacy Practices with respect to the patient.

Name (please print): \_\_\_\_\_  
Relationship to Patient: Parent                      Legal Guardian  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **DOCUMENTATION OF GOOD FAITH EFFORTS (for use by staff only when acknowledgement cannot be obtained from the patient)**

The patient presented to the office on \_\_\_\_\_ and was provided with a copy of Colorado Dermatology Specialists' Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign
- Patient was unable to sign or initial because: \_\_\_\_\_
- The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at next available opportunity.
- Other reason (describe) \_\_\_\_\_

Signature of Employee Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_