ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of Patient:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices provided to me by the office of Aloha Allergy and Immunology, LLC.

_____ _____
Signature of Patient or Authorized Representative

_____
Print Name of Authorized Representative (if applicable)

_____
Date

FOR OFFICE USE ONLY:

A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

_____ Patient refused to accept a copy of the Notice.
_____ Patient received a copy of the Notice but refused to sign acknowledgment form.
_____ Patient was unable to sign because:
_____
_____ Other reason (Describe):
_____

Signature of Employee: _____ Date:_____