Dr. Kyle Raymond
Acknowledgement of Receipt of Notice of privacy practices

Patient Name: _____ Patient ID#: _____
I hereby acknowledge that I have received a copy of Dr.Kyle Raymond'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)
- o Parent or guardian of unemancipated minor
- o Court appointed guardian
- o Executor or administrator of Decedent's estate
- o 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 acknowledgement could not be obtained because:

☐ Patient/representative refused tosign

☐ Emergency situation prevented us from obtaining acknowledgment at this time (Will attempt again at a later date)

☐ Communication barriers prohibited obtaining acknowledgment (Explain)

_____
_____
_____
_____
_____

☐ Other(Specify)

_____
_____
_____