Westchester Park Pediatrics
Affiliated with Boston Children's Health Physicians

ACKNOWLEDGEMENT

(OF RECIEPT OF NOTICE OF PRIVACY PRACTICES)

I hereby acknowledge that a copy of **BOSTON CHILDREN'S HEALTH PHYSICIANS, LLP'S** (hereinafter BCHP) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about **BCHP's** privacy practices or my rights with regard to my personal health information, I may contact **BCHP'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 of Guardian
______________	______________________
Date	Relationship to patient

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT 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 acknowledgement of receipt of BCHP'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 PATIENTS MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES