



I hereby acknowledge that a copy of **Boston Children's Health Physicians, LLP's** (hereinafter BHP) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about **BHP's** privacy practices or my rights with regard to my personal health information, I may contact **BHP'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 BHP'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.