



**WESTERN WASHINGTON MEDICAL GROUP  
ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

By my signature below I, \_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

\_\_\_\_\_  
Signature of client (or personal representative)

\_\_\_\_\_  
Date

**If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:**

Personal Representative's Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

**For Office Use Only**

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date

***This form will be retained in your medical record.***