Asthma & Allergy Physicians of Rhode Island

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ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that I have been either provided a copy or have the Asthma & Allergy Physicians of Rhode Island notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Asthma & Allergy Physicians of Rhode Island and how I may obtain access to and control this information.

Date

(Please Print) Name of patient

(Please Print) Name of personal representative

Signature of patient or personal representative

Description of personal representative's authority

(This section to will be completed if the written acknowledgement is not obtained}

We have made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):

- The individual refuses to sign or otherwise fails to provide an acknowledgement
- The individual was mailed a copy of the Notice and did not mail back his/her receipt of acknowledgement.
- Other:_____

Completed by:_____