

THE HERBERT KANIA PEDIATRIC GROUP
CHILDREN'S & WOMEN'S PHYSICIANS OF WESTCHESTER, LLP
ACKNOWLEDGMENT
(OF RECEIPT OF NOTICE OF PRIVACY PRACTICES)

I hereby acknowledge that a copy of **CHILDREN'S & WOMEN'S PHYSICIANS OF WESTCHESTER, LLP's** (hereinafter CWPW) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about CWPW's privacy practices or my rights with regard to my personal health information, I may contact CWPW'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 CWPW'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.