owasso pediatric
& adolescent medicine

Patient's Name

_____

Patient's Medical Record Number

_____

Patient's Date of Birth (mm/dd/yyyy)

_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy of the **Owasso Pediatric and Adolescent Medicine's** Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____ _____

Date Signature of Patient or Authorized Agent

TO BE COMPLETED BY OWASSO PEDIATRIC AND ADOLESCENT MEDICINE IF NO ACKNOWLEDGEMENT CAN BE OBTAINED:

Good faith efforts were made to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, were:

_____ Patient (or authorized agent) refused to sign after being requested to do so.

_____ Minor presented without parent or authorized agent. Notice of Privacy Practice, acknowledgement form, and self addressed envelope sent home with patient.

_____ Other: (please describe)_____

_____

_____ _____

Signature of Owasso Pediatric and Adolescent Medicine Date