Westchester Park Pediatrics
Affiliated with Boston Children's Health Physicians

ACKNOWLEDGEMENT

(OF RECIEPT OF NOTICE OF PRIVACY PRACTICES)

I hereby acknowledge that a copy of **BOSTON CHILDREN'S HEALTH PHYSICIANS, LLP'S** (hereinafter BCHP) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about **BCHP's** privacy practices or my rights with regard to my personal health information, I may contact **BCHP'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 of Guardian
Date	Relationship to patient

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT 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 acknowledgement of receipt of BCHP'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 PATIENTS MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES