



**PERRY MOLLICK, M.D., P.C.**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (print Patient's name) \_\_\_\_\_, acknowledge and agree that I have received a copy of Perry Mollick, M.D., P.C.'s Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Legal Representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Representative

\_\_\_\_\_  
Relationship to Patient

I authorize the disclosure of my private health insurance information to the following people:

Name	Relationship	Phone#
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FOR PRACTICE USE ONLY:**

Perry Mollick, M.D., P.C. made the following good faith efforts to obtain the above-referenced Patient's written acknowledgement of receipt of the Notice of Privacy Practices:

**[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]**

**Examples:**

- Patient was asked to sign upon check-in but refused to do so
- Because of medical condition, Patient physically unable to sign acknowledgement
- etc.]