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WICHITA FAMILY MEDICINE SPECIALISTS, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Wichita Family Medicine Specialists, LLC Notice of Privacy Practices with the effective date of September 23, 2013(Original April 14, 2003).

_____ _____
Signature of Patient/Personal Representative Date

_____ _____
Relationship to Patient Patient's Name

If you would like someone else to have access to your medical records and information about you, please indicate below. I understand that I may update/change this information at any time by completing a new Acknowledgement of Receipt of Privacy Practices.

_____ Relationship _____ Phone: _____

_____ Relationship _____ Phone: _____

_____Relationship _____ Phone: _____

_____ Relationship _____ Phone: _____

Do we have permission to leave messages on your answering machine?

a) Pertaining to appointments with a physician in our office or with a specialist? Yes No
b) Pertaining to your laboratory or radiology test results? Yes No

For WFMS Use Only

The above named Patient/Personal Representative was provided with a copy of Wichita Family Medicine Specialists' Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgment of his/her receipt of the Notice, but such acknowledgment could not be obtained because:

___ Patient/Personal Representative refused to sign.
___ Patient/Personal Representative was unable to sign.
___ Other reason (please specify):_____

Signature of Workforce Member Completing Form:

_____ _____
Date

Original to be maintained in Patient's medical record