Bryan PHYSICIAN NETWORK

NOTICE OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGMENT OF RECEIPT

Patient Name: _____ DOB: _____

Bryan Physician Network is required by law to maintain the privacy of and provide individuals with this notice of our legal duties and Privacy Practices with respect to protected health information.

I, acknowledge that I received a copy of Bryan Physician Network's Notice of Privacy Practices. I understand Bryan Physician Network has the right to change the Notice of Privacy Practice at any time. I may obtain a current copy upon request.

_____ _____ _____

Patient/Representative Signature | Relationship | Date

For Staff Only

Patient, or patient representative did not sign the acknowledgment for the following reason(s):
Check all that apply

- ❑ Refused
- ❑ Refused, stating that he/she has already signed an acknowledgment
- ❑ Unable to sign because of medical condition
- ❑ There was not a patient representative available to sign
- ❑ Other: (explain) _____

_____

_____ _____

Witness | Date