Rebecca S. Yu, MD
3000 Colby Street # 304 Berkeley, CA 94705 P (510) 540-6800 F (510) 540-6805

Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient name: ________________________________ Date of Birth: ___________________

Signature: ________________________________ Today's Date: ___________________

If reviewed by patient personal representative

Name: ________________________________ Relation to patient: ___________________

Signature: ________________________________ Today's Date: ___________________

I request the following person(s) to use or allow disclosure of my health information:
(In addition to patient/patient representative please list any person(s) with which we may disclose/discuss patient information)

☐ Patient family member or friend: ________________________________

☐ Other person: ________________________________

Detailed messages can be left on answering machine

☐ Yes phone number: (_______)________________________

☐ No

For office use only *when efforts to obtain acknowledgement of receipt of notice are unsuccessful.*
Good Faith Effort to obtain acknowledgement of Notice Receipt
The above named patient / patient representative was provided with the Notice of Privacy Practices & Efforts to obtain signature on acknowledgement of notice form:
□ *offered copy and the individual accepted delivery & signed form*
□ *offered copy and individual refused to accept delivery & refused to sign form*
□ *Other*