

**Dr. Kathleen Ennabi, MD.**  
CHILDREN'S & WOMEN'S PHYSICIANS OF WESTCHESTER, LLP  
**ACKNOWLEDGMENT**  
**(OF RECEIPT OF NOTICE OF PRIVACY PRACTICES)**

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

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**DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN  
ACKNOWLEDGMENT 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 acknowledgment of receipt of CWPW'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 PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.