ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

(rev. 01/2014)

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

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Patient Name   Patient Signature

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Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

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Employee Name   Employee Signature

HIPAA Notice of Privacy Practices
This term does not constitute legal advice and covers only federal, not state, law.