ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

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 acknowledgment, if you wish.

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

Please print your name here:

X_____
Signature:

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 acknowledgment.
_____ We weren't able to communicate with the patient
_____ Other (Please provide specific details)

_____

_____

_____

X_____
Employee Signature

X_____
Date