ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 if you wish.

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

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Please print the patient's name here

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Signature of Patient/ Legal Guardian

____Date Signed

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices 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 the acknowledgment

☐ We weren't able to communicate with the patient

☐ Other (Please provide specific details)

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______________________________ ______________________________

Employee Signature *Date*

This form does not constitute legal advice and covers only federal, not state, law.