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HIPAA NOTICE OF PRIVACY PRACTICES

Effective - 04/21/2015 Revised – 06/19/17

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE 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 are entitled to a copy of this acknowledgement and consent after you sign it. You may refuse to sign this acknowledgement if you wish.

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

_____ _____
Print Your Name Date

_____ _____
Signature

If a personal representative on behalf of the patient is signing this Acknowledgment and Consent, please complete the following:

_____ _____
Print Personal Representative's Name: Relationship to Patient

_____ _____
Personal Representative's Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement 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 were not able to communicate with the patient. (Please provide specific details)
- ☐ Other (Please provide specific details)

_____

_____

_____ _____
Employee's signature Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.