

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*Required Fields

*You May Refuse To Sign This Acknowledgement *

I have received a copy of this Office's Notice of Privacy Practices

Name of Patient:*

Signature of Patient or
Guardian: *

Date:*

Sign

FOR OFFICE USE ONLY

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other

Other please specify: