

Acknowledgement of Receipt of Notice of Privacy Practices



I, _____ acknowledge that I have reviewed this office's Notice of Privacy Practices. I understand that a copy of this Notice will be made available to me at my request.

Please print Name

Signature

Date

Authorization to Use or Disclose my Health Information

The following information is required by law, giving your consent to disclosure of information regarding any aspect of your treatment in our office to any person other than the patient.

I, _____, authorize the release of my Personal Health Information to:

Name

Relationship

Documentation of Good Faith Efforts

On this date, the patient was treated and was given a copy of the Notice of Privacy Practices. An attempt was made to obtain a written acknowledgement of receipt of the Notice; however, an acknowledgement was not obtained because:

patient refused to sign

Communication barriers prohibited obtaining the consent

Patient was unable to sign due to: _____

Signature of employee completing form _____