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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:______________________________________ DOB:____________________

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.

Signature:____ Date:_____________

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but this form could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation, it was not possible to obtain acknowledgement.

☐ We were not able to communicate with the patient.

☐ Other (Please provide specific details):____
____
____

Employee Signature:__________________________________ Date:___________________

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

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