

***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 may refuse to sign this acknowledgement.

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

Print your name

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Privacy form 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 signature.
- We weren't able to communicate with the patient.
- Other (*Please provide specified details*)

Employee Signature

Date

HIPPA Acknowledgment of Receipt of the Notice of Privacy Practices

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