Acknowledgement of Receipt of Notice of Privacy Practices

The Practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form.)

_____

Relationship of Representative

_____

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on _____ . The acknowledgement was not obtained because:

- ❑ The patient was undergoing emergency treatment
- ❑ The patient declined to sign the acknowledgement
- ❑ Other _____

Signature _____

Name of the Patient (Print or Type) _____

Name of Staff Member _____

Date _____