

# 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.

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I acknowledge that I have received a copy of the office's Privacy Policy.

Print name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

FOR OFFICE USE ONLY

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We made every effort to obtain written acknowledgement of receipt of our privacy policy from this patient, but it could not be obtained because:

Patient refused to sign

Due to an emergency situation it was not possible to obtain acknowledgment

We weren't able to communicate with patient

Other (Please provide specific details)

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Employee Signature \_\_\_\_\_

Date \_\_\_\_\_