

**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, if you wish.

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

**Please print your name here**

**Signature**

**Date**

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

1. The patient refused to sign.
2. Due to an emergency situation it was not possible to obtain an acknowledgement.
3. We weren't able to communicate with the patient.
4. Other *(Please provide specific details)* \_\_\_\_\_

**Employee signature**

**Date**