



**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*(will be handed to you on the day of your first visit)*

**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 the acknowledgement, if you wish.

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

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of Our Notice of Privacy and/or signature on Release and Assignment of Benefits form from 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 an acknowledgment.

We weren't able to communicate with the patient.

Other (Please provide specific details)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_