



NOTICE OF PRIVACY PRACTICES HIPAA PRIVACY POLICY ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the HIPAA Privacy Policy. Please let us know if you have any questions or concerns prior to signing this document.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

Guardian Name (if applicable): _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

If individual DID receive the Notice or Privacy Practices but did not sign this acknowledgement of receipt, state efforts and the reason why (refused, unable, left too soon, other):

If individual did NOT receive the Notice of Privacy Practices explain why (emergency treatment, patient declined receipt, other):

Signature of provider representative: _____ **Date:** _____