ACKNOWLEDGEMENT OF NOTICE OF RECEIPT OF PRIVACY PRACTICES

I,_________________________________ have been given an opportunity to read and review this office's Notice of Privacy Practices and understand that a copy is available upon request.

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Signature of patient Date

For Office Use Only

I, _________________________ [Please print full legal name here], acting as _________________________ [Please print relationship to or official position with Provider] for Provider attempted to obtain the written acknowledgment of receipt of the Policy of Provider on _______________ [Please insert date attempt was made], but acknowledgment could not be obtained because:

_____ [Please initial here] Patient or Patient's legal representative refused to sign.

_____ [Please initial here] Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgment.

_____ [Please initial here] Emergency circumstances prevented securing acknowledgment.

_____ [Please initial here] Other (Please specify) _________________________

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Signature of Provider representative Date