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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.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

I authorize access of my medical records to:

Name and Relationship of person we can share information with

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:

- The patient refused to sign.
 - Due to an emergency situation it was not possible to obtain an acknowledgement.
 - We weren't able to communicate with the patient.
 - Other (Please provide specific details)
- _____
- _____

Employee signature

Date