ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

Patient Name:____

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices.

By signing below, you acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me

I have been given the opportunity to ask any questions regarding this Notice.

______________________________	______________________
Signature of Patient or Responsible Party	Date

____
Relationship if not patient

I authorize the following person(s) to have access to my information covered under the Priviacy Practices regarding myself:

______________________________	______________________
{NAME}	{RELATIONSHIP}
{NAME}	{RELATIONSHIP}
{NAME}	{RELATIONSHIP}

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of availablity of our Notice of Privacy Practices, But acknoweldgement could not be obtain because:

__________ Individual refused to sign
__________ Communication barriers prohibited obtaining the acknowledgement
__________ An emergency situation prevented us from obtaining the acknowledgement
__________ Other (Please specify)