PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment and health care operation purposes.

Signature: _____

Print Name: _____

Patient Representative (if minor): _____

Date: _____

Witness: _____

I give permission to speak to _____

Relationship to patient: _____
Regarding my treatment as needed.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign.

☐ Communications barriers prohibited obtaining the acknowledgements.

☐ An emergency prevented us from obtaining acknowledgements.

☐ Other (Please Specify):