



Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of this practice's HIPAA Notice of Privacy Practices.

Patient Name (Please Print)

Patient Signature

Date

OR

Signature of Personal Representative

Date

Authority of Personal Representative to Sign for Patient (Check One):

- ☐ Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use ONLY: I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because

- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ A communication barrier prevented us from obtaining acknowledgement
- ☐ The individual was unwilling to sign
- ☐ Other: _____

Staff Member Printed Name

Staff Member Signature

Date