Acknowledgment of Receipt
"NOTICE OF PRIVACY PRACTICES"

I acknowledge that I have received a copy of the *"Notice of Privacy Practices"* for protected health information on the date set forth below.

____
Date of Receipt

____
Patient Date of Birth

____
Print Patient Name

____
Print Name of Authorized Personal Representative

____
Patient Signature

____
Signature of Authorized Personal Representative

____
Please Indicate Relationship to Patient

FOR USE BY PRACTICE PERSONNEL ONLY

*(Complete only if patient acknowledgement is **not** obtained)*

An Acknowledgement of Receipt of Notice of Privacy Practices was not received because:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication / language or another barrier
- ☐ Patient was unable to sign Acknowledgment due to emergency treatment situation
- ☐ Other (*please indicate reason):* ____

____
Staff Signature