PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This Notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations. This form will be filed in the patient's medical record.

_____ _____
Patient Name Date of birth

_____ _____ _____
Please **Print** your name Please **Sign** your name Date

_____
Description of Authority

Office Use Only

An attempt was made to obtain the patient's or legal representative's signature on this Acknowledgement but did not because:

It was emergency treatment _____
Inability to communicate with patient _____
Patient refused to sign _____
Patient was unable to sign _____ Reason: _____
Other: _____

_____
Signature of Privacy Officer