



Acknowledgement of Receipt Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Print Patient Name: _____ Date: _____

Signature of Patient Name: _____ Date: _____

Information below is Optional

I, _____, am the *personal representative* and have legal authority to make health care decisions about patient:

Print Patient Name: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

Authorization for Additional Disclosure

I authorize the following individuals to have access to my health information:

- 1) _____ Relationship: _____
- 2) _____ Relationship: _____
- 3) _____ Relationship: _____

Patient Signature: _____ Date: _____

For Office Use Only

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

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