ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy of the Notice of Privacy Practices will be provide upon request.

I acknowledge that I have been made aware of this office's Notice of Privacy Practices. I may refuse to sign this acknowledgement if I wish.

_____ _____

Patient's Name *Patient's Date of Birth*

_____ _____

Please print your name here (if different from above) *Relationship to Patient*

_____ _____

Signature *Today's date*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

The parent/patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the parent/patient.

Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*