



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: \_\_\_\_\_

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

( ) I have received the Notice of Privacy Practices (effective date) \_\_\_\_\_

\_\_\_\_\_  
Patient's (or Legal Representative's) Signature Date

\_\_\_\_\_  
Relationship of Legal Representative

*For office use only*

To be completed only if Acknowledgement is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?  
( ) Yes ( ) No

2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient's signature:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name/Title Date