ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Notice to Patient:

We are required by low to provide a copy of our Notice of Privacy practice to you, which states how we may use and or/disclose your health information. Please sign the form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.

_____
Please print your name here

_____
Signature of Patient

_____
Date

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Your PHI maybe be disclosed to the individuals you list below. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

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 patient refused to sign
- □ Due to an emergency it was not possible to obtain acknowledgment
- □ We were not able to communicate with the patient.
- □ Other (Please provide specific details)

_____
_____
_____

_____ _____
Employee Signature Date