Patient Acknowledgment of Receipt of Privacy Practices Notice

lease Pri	int
,	, hereby acknowledge that I have reviewed and received a cop
of this	s office's Notice of Privacy Practices explaining:
	How this office will use and disclose my protected health information.
	My privacy rights with regard to my protected health information.
	■ This office's obligations concerning the use and disclosure of my protected health information.
	erstand that the <i>Notice of Privacy Practices</i> may be revised from time to time and that I am entitled to receive a copy of any revised <i>e of Privacy Practices</i> upon request.
also	understand that if I have any questions or complaints, I may contact:
Pa	tient or Personal Representative ture: Date: Date:
Vame	*
	Please Print
Relati	onship to Patient:
	For Office Use Only
	We made a good-faith effort to obtain an acknowledgment of
	☐ Patient refused to sign (date of refusal)/
	☐ Communications barriers prohibited obtaining an acknowledgment.
	☐ An emergency situation prevented us from obtaining an acknowledgment.
	□ Other
	Attempt was made by: Date:/ /



