

Your Practice Name
Your Address
City, State, Zip

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

“YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT”

I, _____, have received a copy of this office’s
Notice Of Privacy Practices.

Patient’s Name *Please Print*

Signature of Patient (Parent or Guardian if Child)

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but 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 (Please Specify)

