

Acknowledgement of Receipt of Notice of Privacy Practices



Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy and that I may request a copy of any amended Notice of Privacy.

Signed: _____ Date: _____

Print Name: _____

If not signed by patient, please complete below:

Relationship to Patient: Check below

Parent Legal Guardian Conservator Patient's Representative

For Office Use Only:

Acknowledgement refused:

Efforts to obtain:

Reasons for refusal:

