TJM

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient. It could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was impossible to obtain an acknowledgement.
- ☐ We were not able to communicate with the patient.
- ☐ Other (specify below)

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_____ _____

Employee Signature *Date*