

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

SECTION A

THE PATIENT

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C

GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign this form: _____

SIGNATURE

SIGNATURE:

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this knowledge of receipt in the individual's records.