ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that this Medical Practice has given you a copy of its
Notice of Privacy Practices. This notice explains how your health information will be handled.
HIPAA, the new Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. The Medical Practice has given me the
opportunity to ask any questions about this notice and all my questions have been answered.

Patient's Signature or Guardian

You may discuss my medical condition with:

Date Signed

Provider Use Only
If patient was not able to sign due to an emergency, or did not want to sign, please
document if patient was given the notice and the reason why the patient did not sign
below.

Patient was given the notice ______Yes ______No

Reason signature was not obtained ____________________________

Staff Signature ____________________________ Date ______