



ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient's First Name: _____ Last Name: _____

Date of Birth: _____

YOU MAY REFUSE TO SIGN THIS AGREEMENT.

I give consent for the Use and Disclosure of Health Information of myself and/or my dependent(s) for the purpose of the Treatment, Payment or Communication between other healthcare professionals.

I understand that I have the right to review a copy of this office's Notice of Privacy Practices prior to signing the condensed form.

Signature of Parent/Guardian Date: _____

Name of Parent/Guardian: _____

Relationship to Patient: _____

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):
