# **ACKNOWLEDGMENT OF RECEIPT OF NOTICE**

**Patient Name:**

By signing this form, you agree that you received a copy of the *Notice of Privacy Practices* of [fill in name of state entity]. Our *Notice of Privacy Practices* tells you how we may use and disclose your protected health information. We ask that you read all of it.

I received a copy of the *Notice of Privacy Practices* of [fill inname of state entity].

**Date:** \_\_\_\_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_ a.m./p.m. **Signature:**

Patient or Legal Representative

If signed by someone other than patient, indicate relationship:

**Print name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative

**Office Use Only:**

# **INABILITY TO OBTAIN ACKNOWLEDGMENT**

Description of good faith effort and reason why Acknowledgment was not obtained:

**Patient Name:**

**Good Faith Effort:**

☐ Provided copy of notice to patient or legal representative

☐ Presented Acknowledgement to patient or legal representative for signature

☐ Other:

**Reason(s) why the Acknowledgment was not obtained:**

☐ Patient or legal representative refused to sign

☐ Other:

**Provider Representative Signature:**

**Provider Representative Name:**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_\_ a.m./p.m.