

# NOTICE OF PRIVACY PRACTICES:

## *Acknowledgement of Receipt*

### **ACKNOWLEDGEMENT OF RECEIPT**

By signing this form, you acknowledge receipt of the “Notice of Privacy Practices” of [name of covered entity]. Our “Notice of Privacy Practices” provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our “Notice of Privacy Practices” is subject to change. If we change our notice, you may obtain a copy of the revised notice by: [accessing our website / contacting our organization at 1-800-\_\_\_\_\_-\_\_\_\_\_/ insert alternative].<sup>1</sup>

If you have any questions about our “Notice of Privacy Practices,” please contact: [insert contact information]

I acknowledge receipt of the “Notice of Privacy Practices” of [name of covered entity].

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
*(patient/legal representative)*

If signed by someone other than the patient, indicate relationship: \_\_\_\_\_

Print Name: \_\_\_\_\_  
*(legal representative)*

(over)

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<sup>1</sup> This section applies only if the Covered Entity has reserved the right to change its privacy practices. It is recommended that providers reserve this right.

**INABILITY TO OBTAIN ACKNOWLEDGEMENT**

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient Name: \_\_\_\_\_

Reasons why the acknowledgment was not obtained:

Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices

Other: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
*(provider representative)*

Print name: \_\_\_\_\_  
*(provider representative)*