



# ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### For Office Use Only

**We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:**

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Staff signature

\_\_\_\_\_  
Date