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Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

Patient Name:* _____ * _____ _____ _____
Last First MI Preferred Name

I have received a copy of this office's Notice of Privacy Practices.

Comments/Disclosure Restrictions:

You May Refuse to Sign This Acknowledgement

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:

- ☐ Patient refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify Below)

Other:

Response Date: