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|  | Name of Medical Practice PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES | | |
|  | | The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This Notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment, or in the performance of health care operations. This form will be filed or documented electronically within the patient’s medical record. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PATIENT NAME DATE SIGNATURE  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LEGAL REPRESENTATIVE *(if not the patient)* DATE Description of Authority  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **OFFICE USE ONLY**  An attempt was made to obtain the patient’s or legal representative’s signature on this Acknowledgement of Receipt but did not because:  \_\_\_\_\_\_\_\_\_ Patient was seen for an emergency treatment  \_\_\_\_\_\_\_\_\_ Inability to communicate with the patient  \_\_\_\_\_\_\_\_\_ Patient refused to sign  \_\_\_\_\_\_\_\_\_ Patient was unable to sign  Other reason(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Employee Date Position  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Privacy Officer Date |
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