

Acknowledgement of Notice of Privacy Practices

By signing this form, you acknowledge that you have received our Notice of Privacy Practices.

The Notice of Privacy Practices describes in detail how we might use or disclose your protected health information as well as your rights and our duties with respect to your protected health information.

You have the right to review the Notice of Privacy Practices before signing this acknowledgment.

By signing this form, you acknowledge that medical information collected by _____ will be stored in a medical record system operated by _____, and kept securely in line with state and federal regulations.

Signature of Patient or Legally Authorized Representative

Date

Printed Name of Patient or Legally Authorized Representative

Relationship to Patient

For Office Use Only

If the patient refused or was unable to acknowledge the Notice of Privacy Practices, please explain why:

