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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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**\* You May Refuse to Sign This Acknowledgement \***

For Patient: \_\_\_\_\_

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

I also give my consent to share my/the patient's health related information with the following people:

\_\_\_\_\_  
Name and relationship to the patient

\_\_\_\_\_  
Name and relationship to the patient

\_\_\_\_\_  
Name and relationship to the patient

\_\_\_\_\_  
Name and relationship to the patient

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\_\_\_\_\_  
Please print your name

\_\_\_\_\_  
Signature (if the patient is a minor, your signature indicates that you are a legal guardian)

\_\_\_\_\_  
Date

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**For Office Use Only**

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

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

\_\_\_\_\_  
\_\_\_\_\_  
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