**Add logo here

Acknowledgment of Receipt of Notice of Privacy Practices**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), 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 multiple health care providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that **[NAME OF ENTITY]** (“Practice”) has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

**Do we have your permission to:**

Leave a message on your answering machine? [ ]  Yes [ ]  No
Confirm appointments by leaving messages or speaking with family? [ ]  Yes [ ]  No
Leave pre-medication reminders (if applicable)? [ ]  Yes [ ]  No
Speak to household members concerning your care? [ ]  Yes [ ]  No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|            |  |            |  |            |
| **Patient name** |  | **Signature**  |  | **Date** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|            |  |            |  |            |
| **Name/relationship to patient**  |  | **Signature**  |  | **Date** |

**FOR OFFICE USE ONLY**

Practice provided the above-referenced patient with the Practice’s Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

|  |  |
| --- | --- |
| [ ]  Patient or guardian refused to sign |  |
| [ ]  Emergency situation |  |
| [ ]  Other: |                                                                                                           |

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