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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: (print) _____ Patient Signature: _____ Date: _____

For Office Use Only:

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Attempt: (patient name): _____ Date: _____ Received by: _____

Rev: 09/01/2013