



**Acknowledgment Of Receipt
Of Notice Of Privacy Practices**

(You May Refuse to Sign This Acknowledgment)

I, _____, have received a copy of the NOTICE OF PRIVACY PRACTICES. I hereby authorize you to share/disclose my health information with the following persons/parties:

PRINT NAME: _____

SIGNATURE OF PATIENT SIGNATURE OF LEGAL GUARDIAN

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority/relationship.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES document, but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign because