Notice of Privacy Practices

PT NAME: _____
MRN NO# : _____

Acknowledgment of Receipt

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of [_____], and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

I authorize the following person(s) access to the use or disclosure of my health information. I understand that this authorization is in effort until revoked in writing.

Name/Relationship:
_____

Name/Relationship:
_____

Signature: _____ Date: _____

Printed Name: _____

Signature of Parent/Guardian (specify which):
_____

Date: _____

For Office Use Only

Notice of Privacy Practices sent/delivered on _____. Initials _____

Signed Acknowledgment of Receipt received on _____. Initials _____

Patient Refused or Failed to Acknowledge Receipt on _____. Initials _____