



# Acknowledgement of Receipt Notice of Privacy Practices

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

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_, am the *personal representative* and have legal authority to make health care decisions about patient:

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization for Additional Disclosure

I authorize the following individuals to have access to my health information:

- 1) \_\_\_\_\_ Relationship: \_\_\_\_\_
- 2) \_\_\_\_\_ Relationship: \_\_\_\_\_
- 3) \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (specify): \_\_\_\_\_

# This form is optional