Acknowledgement of Receipt of Privacy Practices

Patient's Name:	**DOB:**

The practice reserves the right to modify the privacy practices outlined in this notice.

☐ I received a copy of the Notice of Privacy Practices.

_____

Patient Signature **Date**

_____

Signature of Patient's Representative
(Required if patient is a minor or adult who is unable to sign this form)

_____

Relationship to Patient

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

The Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

- ☐ The patient declined to sign the agreement
- ☐ Other: _____

_____

Staff Signature **Date**