**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I am acknowledging that:

* I am either the patient or the patient’s personal representative;
* I have received a copy of the “Notice of Privacy Practices” for (Insert Name of Practice); and
* I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/legal guardian/legally responsible person

\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of relationship to patient

**TO BE COMPLETED BY STAFF**

Complete all applicable parts—Please refer to instructions

*Part 1. Complete if signature requested but not obtained:*

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient’s personal representative for the following reason:

* Patient/personal representative refused to sign form
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:*

* Form mailed/sent to patient/personal representative on (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Part 3. Complete if either Part 1 or Part 2 completed:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of staff member Date

**MI AVISO DE PROCEDIMIENTOS DE PRIVACIDAD**

Nombre del Paciente: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de Nacemiento: \_\_\_\_\_\_\_\_\_\_\_\_

Firmando abajo, estoy reconociendo eso:

* Soy del paciente el representante personal paciente o;
* He recibido una copia del aviso de procedimientos de privacidad para (Insert Name of Practice); y
* Entiendo que puedo entrar en contacto con a la persona nombrada en el aviso si tengo preguntas sobre el contenido del aviso.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma del paciente o del padre/del guarda legal/de la persona legalmente responsable

\_\_\_\_\_\_\_\_\_\_\_\_

Fecha

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Descripción de la relación al paciente

**PARA SER COMPLETADO POR EL PERSONAL / TO BE COMPLETED BY STAFF**

Complete all applicable parts—Please refer to instructions

*Part 1. Complete if signature requested but not obtained:*

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient’s personal representative for the following reason:

* Patient/personal representative refused to sign form
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:*

* Form mailed/sent to patient/personal representative on (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Part 3. Complete if either Part 1 or Part 2 completed:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of staff member Date