



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

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices and have been offered a copy to keep.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

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WRITTEN ACKNOWLEDGMENT NOT OBTAINED

Please document your efforts to obtain acknowledgement and reason it was not obtained.

- Patient unable to sign
- Patient declined to sign

\_\_\_\_\_  
Signature of Staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name