



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact his organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

Please Print name (Parent or Guardian, if minor)

Signature (Parent or Guardian, if minor)

Date

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- This authorization can be revoked at any time with my written permission.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization for research-related treatment, in which case you may refuse to provide that research-related treatment).

OFFICE USE ONLY

I attempted to obtain patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented: (Date)_____ (Initials)_____ (Reason)_____

