



## Acknowledgment of Receipt of Notice of Privacy Practice

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices*. Our notice of *Privacy Practices* provides information about how the office may use and disclose your protected health information. We encourage you to review it carefully. The patient has the right to receive a paper copy of the notice at any time. The patient also reserves the right to refuse to sign such acknowledgment.

I acknowledge receipt of the *Notice of Privacy Practices*.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### For Office Use Only

We attempted to obtain written acknowledgment of receipt of our *Notice of Privacy Practices*, but acknowledgment could not be obtained. Reason why acknowledgment was not obtained:

- Individual refused to sign
- Other (Please Specify) \_\_\_\_\_