ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

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I have received the notice of Privacy Practices. This Notice provides information about how my protected health information may be used or disclosed.

Date _____ Time _____ Signature (Patient/Representative) _____

If signed by other than the patient, print name and relationship.

Name _____ Relationship _____

Witness(es) (2) only required for telephone consent, physical inability to sign, or signature by mark:

Date _____ Time _____ Witness _____ Witness _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT
(Complete Only If No Signature Is Obtained)

A good faith effort has been made to obtain the acknowledgement above. At this time, the following circumstances exist:

- The patient refuses to sign
- The patient is not able to sign and there is no legal representative available.

Date _____ Time _____ Signature of Employee _____