Patient Acknowledgement of Receipt of Notice of Privacy Practices

Use: 1] Required by the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164; For authorization for use or disclosure of Protected Health Information. 2] Describes how health information about you may be used and disclosed and how you can get access to this information. 3] Completed and signed by the patient or personal representative.
4] Scanned and/or filed in patient's record.

The privacy of your health information is important to us. Please review this information carefully.

____________________________________ __________________________

Print Patient's Name **Date**

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. In addition, we are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

____________________________________ ______________________

Patient Signature **Date**

Office Use Only

We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Patient Name: ________________________________

- ☐ Individual Refuses to Sign
- ☐ Communication Barriers – prohibited obtaining the acknowledgement
- ☐ Emergency Situation – prevented us from obtaining the acknowledgement
- ☐ Other – please explain: ____

____________________________________ ______________________

Staff Signature **Date**

Disclaimer: This sample document is intended to serve only as a general resource, not as a form or recommendation. It has not been approved, sanctioned, or officially promulgated by any state or by any attorney, nor is it intended to represent the standard of practice in any state. This is a sample only and information may not be in compliance with the April 14, 2003 HIPPA Guidelines.

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