ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices**. I give authorization for the doctor or staff to discuss information concerning my**

- Health History _____ (initial)
- Financial Issues _____(initial)
- Treatment Planning _____(initial)

with (name of person/persons) _____.

I do not give permission to release or discuss my records to anyone outside the state or federal mandates. _____

A copy of the Power of Attorney has been provided. Yes / No

Print Patient or Representative Name _____

Patient or Representative Signature _____

Date _____

For Office Use Only

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

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify) _____

_____