ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This notice describes the types for users and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care options. This form will be filed in the patient's medical record.

_______________________	___________	_______________________
Please **Print** your name	Date	Please **Sign** your name
_______________________	___________	_______________________
Legal Representative	Date	Description of Authority

Office Use Only:

An attempt was made to obtain the patient's or legal representative's signature on the Acknowledgment but did not because.

It was emergency treatment ________
Inability to communicate with patient ________
Patient refused to sign ________
Patient was unable to sign ________ Reason: ________
Other: ____

RECEIPT 12/16