Acknowledgement of Receipt of Notice of Privacy Practices
(to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: ____ Date: ____________________

Relationship (if not signed by patient): ____

I wish to have the following restrictions on disclosure of my health information:

____

Office Use Only
If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date/time): ____________________ By (name/title): ________________________