HIPAA Acknowledgement

Notice of Privacy Practices

Printed Name of Patient: ______________________________

Patient Date of Birth: ______________________________

I acknowledge receipt of Advocare's Notice of Privacy Practices.

Signature of Patient/Legal Representative: ______________________ Date: ____________

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Office Use:

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: ______________________________

Signature of Advocare Representative: ______________________________

Printed Name: ______________________ Date: ____________