Acknowledgement of receipt of Notice of Privacy Practices

(To be filed in patient's medical records)

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.

Patient Signature: _____

Parent/ Legal Guardian Signature (if minor): _____

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

_____

_____

_____

Internal Use Only

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

Presented on (DATE/TIME): _____

By (STAFF MEMBER NAME): _____