PATIENT ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES (NPP)

Patient's Name: ____

DOB: _______ / _______ / _______

I understand that:

- The law does not require me to sign this form
- Signing this form does not mean I have agreed to any special uses of my medical record
- Refusing to sign this form does not prevent the provider from using my health information as HIPAA permits

I acknowledge that the Notice of Privacy Practices given to me by [INSERT PRACTICE NAME]

____ ___________________

Patient or Legal Representative Signature Date

If Signed by Legal Representative, Relationship to Patient: ___________________________________

OFFICE USE ONLY: If patient does not sign above acknowledgement

Reason why acknowledgement could not be obtained:

_____ Patient refused to sign

_____ Emergency situation, unable to secure signature

_____ Other - please explain:

____

____

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Print Staff Member Name

____ ______________________

Staff Member Signature Date