# [Insert Letterhead]

# Receipt of Notice of Privacy Practices

Notice to patient:

We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. By signing below, you acknowledge that you have received our Notice of Privacy Practices.

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Patient’s name Patient’s Date of Birth

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Personal Representative name Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**For Office Use Only**

In the case that written acknowledgement could not be obtained, please select reason below.

 \_\_\_ Patient/Personal Representative refused to sign.

 \_\_\_ Patient/Personal Representative was unable to sign.

 \_\_\_ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

 \_\_\_ Other reason (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Workforce Member Completing Form Date