

# Acknowledgment of Receipt Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. By signing below I consent for the use of my personal health information for treatment, payment and operations and other uses as described in the privacy notice. I also understand that I have the right not to sign this agreement.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

.....

If we are unable to get your acknowledgment then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgment was not obtained:

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

Staff Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_