



Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that [NAME OF ENTITY] ("Practice") has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Do we have your permission to:

- | | | |
|---|------------------------------|-----------------------------|
| Leave a message on your answering machine? | ☐ Yes | ☐ No |
| Confirm appointments by leaving messages or speaking with family? | ☐ Yes | ☐ No |
| Leave pre-medication reminders (if applicable)? | ☐ Yes | ☐ No |
| Speak to household members concerning your care? | ☐ Yes | ☐ No |

Patient name

Signature

Date

Name/relationship to patient

Signature

Date

FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

☐ Patient or guardian refused to sign

☐ Emergency situation

☐ Other: _____