



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you are acknowledging that you have received a copy of the Notice of Privacy Practices.

Patient's Printed Name

DOB

Patient's or Authorized Personal Representative's Signature

Date

Office Staff Use Only

Indicate why a sign acknowledgement could not be obtained:

- The patient refused to sign this form.
- Emergency situation prevented our practice from obtaining the patient's signature.
- The NPP was mailed or emailed to the patient per request.

Mailing Address: _____ Date mailed: _____

Email Address: _____ Date emailed: _____

Other Reasons: _____

Employee's Printed Name

Employee's Signature

Date: _____

****Scan into Patient's Electronic Medical Record****