HIPPA PRIVACY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (Print full legal name here; the "Patient" or "Patient's Legal Representative"), have been provided with a copy of the policy.

Please initial one line only below.

_____ I hereby acknowledge that I have been provided with a copy of the policy.

_____ I hereby refuse to acknowledge receipt of the policy. I understand that even though I may refuse to sign this acknowledgement, my provider may still provide services.

Signature (Must be 18 yrs. or older to sign) Date

Refused to Sign Notice of Privacy Practices

Reason_____
_____
_____
_____
_____
_____

_____
Employee Signature Date