ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES
OF (name of facility, city & state and zip code)

Patient Name

Medical Record Number

Signature _____ Date _____

Capacity in which signed (if other than patient)

The Acknowledgement of Receipt for the above individual was not received due to:

___ Individual refused to sign

___ Individual unable to sign

___ Other (explain reason unable to obtain acknowledgement and efforts to obtain)