ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge: A copy of the Notice of Privacy Practices was given to me.
If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_________________________________________________ ________________________________
Signature of Patient or Representative  Date

_________________________________________________
Print Name

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FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient’s name: _________________________________________________________

Date of attempt to obtain acknowledgment: _________________________________

Reason acknowledgment was not obtained:
☐ Patient/family member received notice but refused to sign acknowledgment
☐ Emergency treatment situation
☐ Patient was incapacitated and no family member was present
☐ Unable to communicate due to language barriers
☐ Other (please describe below)

________________________________________________________________________________________

________________________________________________ _____________________________________
Signature of Employee  Date