HIPAA NOTICE ACKNOWLEDGEMENT

WHY ARE YOU RECEIVING THIS NOTICE OF PRIVACY POLICY?

The HIPAA Privacy Rule requires your health care provider to give you a notice that tells you how they may use and share your health information and how you can exercise your health privacy rights. This form acknowledges that you have received a copy of our Privacy Practices or that we have made a good faith effort to obtain that acknowledgment.

PATIENT NAME: ____

TO THE INDIVIDUAL: Please complete the following acknowledgement.

❑ I acknowledge that I received the Privacy Practices Notice of this health care provider.
(Please sign in the space indicated below)

TO THE PHYSICIAN REPRESENTATIVE: Please complete the following if the patient is unable to sign and sign in the space below.

If the individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice, please check appropriate box below. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful.

❑ Individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice.

❑ Individual received our Privacy Practices Notice in connection to an emergency treatment situation. We are therefore not required to obtain an acknowledgement.

THIS FORM HAS BEEN SIGNED BY: (please check one)

❑ PATIENT

❑ PATIENT'S PERSONAL REPRESENTATIVE

❑ PHYSICIAN REPRESENTATIVE

I attest that the above information is correct.

______________________________ ______________________
Signature Date

____
Printed Name

____
Witness Signature