Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that **[NAME OF ENTITY]** ("Practice") has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Do we have your permission to:

Leave a message on your answering machine?	☐ Yes	☐ No
Confirm appointments by leaving messages or speaking with family?	☐ Yes	☐ No
Leave pre-medication reminders (if applicable)?	☐ Yes	☐ No
Speak to household members concerning your care?	☐ Yes	☐ No

Patient name	**Signature**	**Date**
Name/relationship to patient	**Signature**	**Date**

FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

☐ Patient or guardian refused to sign

☐ Emergency situation

☐ Other: _____