

**HIPAA Privacy Rule**  
**Receipt of Notice of Privacy Practices**  
**Written Acknowledgement Form**

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I, \_\_\_\_\_ (patient's name), understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this change an updated copy will be posted in the waiting room.

Signature of Patient or Legal Representative \_\_\_\_\_

Printed Name of Legal Representative (if applicable) \_\_\_\_\_

Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Others (please specify)

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