ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement**

I, ______________________________, have received a copy of this office’s Notice of Privacy Practices.

____________________________________   __________________________________
Please Print Name                                     Relation to the Patient(s)

____________________________________   ________________
Signature (Patient Signature if 18yrs. or older)        Date

May we send a ‘Thank You’ with your name and your child’s name to your referral source?
Yes______ No_______

For Office Use Only

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

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)