

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices and all forms required under the Health Insurance Portability and Accountability Act (HIPAA).

Printed Name

Signature

Date

If you are the legal representative of the patient, please print the patient's name(s) below and describe your authority.

Thank you. If you have any questions about this form, or the attached Notice of Privacy Practices, please contact Dr. Lauren Yerkes.

For Office Use Only

As a privacy officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgment, but could not because:

- _____ It was emergency treatment.
- _____ The patient (or representative) refused to sign.
- _____ The patient (or representative) was unable to sign because:

_____ Other (Please describe):

Signature of privacy officer: _____ Date: _____