The Practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices to read.
I understand that if I wish to keep a copy, I will receive one upon request.

_____
Name of Patient (Print or type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign.)

_____
Relationship of Representative

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of the receipt of the Notice of Privacy Practices on _____. The Acknowledgement was not obtained because:

- ☐ The patient was undergoing emergency treatment
- ☐ The patient declined to sign the acknowledgement
- ☐ Other _____

Name of Patient: _____

Name of Staff Member: _____

Signature of Staff Member: _____ Date: _____