ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

***********You May Refuse to Sign This Acknowledgement*********

Date:_____

I, _____have received a copy of this office's Notice of Privacy Practices.

Print Guardian's Name:_____

Print Patient's Name:_____

Guardian's Signature: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____
{Please Print Name} Relationship

_____
{Please Print Name} Relationship

_____
{Please Print Name} Relationship

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) _____