



Acknowledgement of Notice of Privacy Practices Form

Revision
Number:
001

I have been given a copy of this Office's *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office's HIPAA Compliance Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

For Facility Use Only: *Complete this section if you are unable to obtain a signature.*

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement*:

Completed by	
Signature of Facility Representative	
Date	