



## 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\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself 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 acknowledgment 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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_