

**Patient Acknowledgement of Receipt of  
Notice of Privacy Practice**



I have received a copy of this office's **NOTICE OF PRIVACY PRACTICES**. It provides information about how the office may use and disclose your Protected Health Information (PHI).

I have been provided an opportunity to review the Notice of Privacy Practices.

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***Patient Name***

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***Patient Signature (or Parent)***

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***Date***

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**FOR OFFICE USE ONLY**

We made a "good faith effort" to obtain written acknowledgement of receipt of our ***NOTICE OF PRIVACY PRACTICES***. However, we were unable to obtain acknowledgement for the following reason:

Patient refused to sign

Other: \_\_\_\_\_

*(Possible reasons: language difficulty, communication barriers, etc.)*

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***Patient Name***

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***Patient Signature (or Parent)***

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***Date***