

HIPAA Acknowledgment Form

I am required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY:

I have made every effort to obtain written **acknowledgment** of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgment.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*)

Therapist Signature

Date