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.

I, *(patient or parent of patient)* ______________________________, have received a copy of this office's Notice of Privacy Policies.

Please print patient name: ______________________________

Signature *(patient or parent of patient)*: ______________________________

Date: ______________________________

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This for is to obtain acknowledgement to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, *(patient or parent of patient)* ______________________________, 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 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
- Other