ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

Patient name: _____

Social Security #: _____

Date of Birth: _____

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____ _____

Signature of Patient Date

Relationship (if not signed by patient) : _____

I wish to place the following restrictions on disclosure of my health information:

Internal Use Only

If patient/patient's representative refuses to sign acknowlegment, please document and time notice was presented to patient and sign below.

Presented on (Date and Time): _____

By (Name and Title): _____