

## *Acknowledgement of Notice of Privacy Practices Form*

I have been given a copy of this Office's *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office's HIPAA Compliance Officer.

**My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:**

<b>Signature of Patient or Personal Representative</b>	
<b>Patient Name</b>	
<b>Name of Personal Representative (if applicable)</b>	
<b>Date</b>	

**For Facility Use Only: Complete this section if you are unable to obtain a signature.**

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

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2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement*:

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<b>Completed by</b>	
<b>Signature of Facility Representative</b>	
<b>Date</b>	