HIPAA Acknowledgment Form

We are 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:

We 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