

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at [*insert telephone number*].

If you have any questions about my *Notice of Privacy Practices*, please contact me at: [*insert address and telephone number*].

I acknowledge receipt of the *Notice of Privacy Practices* of [*name of covered entity*].

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(*patient/parent/conservator/guardian*)

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**INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including [*describe good faith attempts*]. However, because of [*insert reasons why acknowledgement was not obtained*] I was unable to obtain my patient's acknowledgement.

Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_