Acknowledgement of Receipt
Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. **By signing below I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice**. I also understand that I have the right not to sign this agreement.

Name:_____________________________

Signature:__________________________

Relationship to Patient:_______________

Date:______________________________

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

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Staff Name:________________________________

Signature: _________________________________

Date:_____________________________________