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## Acknowledgement of Receipt of Notice of Privacy Practices

*This form will be retained in your medical record.*

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### NOTICE TO PATIENT

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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.

- **Patient Name:** \_\_\_\_\_
- **Date of Birth:** \_\_\_\_\_

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Valley Chiropractic Clinic, Inc

I understand that the Notice describes the uses and disclosures of my protected health information by Valley Chiropractic Clinic, Inc. and informs me of my rights with respect to my protect health information.

**X** \_\_\_\_\_

*Patient's Signature of that of Legal Representative*

**X** \_\_\_\_\_

*Printed Name of patient or that of Legal Representation*

**X** \_\_\_\_\_

*If Legal Representative, indicate Relationship*

**X** \_\_\_\_\_

*Today's Date*

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### FOR OFFICE USE ONLY

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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 acknowledgement.
- Communications barriers prohibited obtaining the acknowledgement.
- Other (please specify): \_\_\_\_\_

**X** \_\_\_\_\_

*Employee Name*

**X** \_\_\_\_\_

*Today's Date*