

# Acknowledgement of Receipt of Privacy Practices for Protected Health Information

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Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, has been given a copy of this office's Notice of Privacy Practices.  
*Print Patient Name {Nombre del Paciente}*

\_\_\_\_\_  
*{Signature of Patient or Parent if Minor} {Firma del Paciente o Padres/sies menor Guardian}*

\_\_\_\_\_  
*{Date}*

## For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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