HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

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.

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Country Day Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

By signing this form (the “Acknowledgement”), you acknowledge receipt of the Notice of Privacy Practices (NPP). Our NPP provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

- I acknowledge receipt of this NPP.

Patient’s Signature: ____

Date:_________________________________

Patient’s Name (Please Print): ____

- If this Acknowledgement is being signed by a personal representative (such as a parent or guardian) on behalf of the patient, complete the following:

  Personal Representative’s Name(Please Print): ___________________________________

  Description of Personal Representative’s Authority:________________________________

Inability to Obtain Acknowledgement

- If it is not possible to obtain the individual’s Acknowledgement, describe the good faith efforts made to obtain the Acknowledgement, and the reasons why the Acknowledgement was not obtained.

  Patient Name: ____

Reasons why the acknowledgement was not obtained:

- Patient refused to sign the Acknowledgement even though the patient was asked to do so and the patient was given the NPP.
- Other: ____

Provider Representative Signature: __________________________________

Date: __________________________________

Provider Representative Print Name: __________________________________