PATIENT NAME (print) _____ DATE: _____

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.

You may refuse to sign this acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Patient Name (printed)

_____
Signature

_____
Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

For Office Use Only

We attempted to obtain written acknowledgment 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 the acknowledgment
____ Other (Please specify)
_____
_____
_____