HIPPA Privacy Rule

Receipt Of Notice Of Privacy Practices

Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§ 164.520).

I _____ (patient's name) understand that as part of my healthcare, this facility originates and maintains medical records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's' Notice of Privacy Practice provides a complete description of the uses and disclosure of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practice prior to signing this acknowledgement.

- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address that I've provided if requested.

Signature of Individual or Representative Witness:_____

Printed Name of Individual or Legal Representative:_____

Date:_____