HIPAA Privacy Rule
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health 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 Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices 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 I've provided if requested.
- I consent to IMC's use and disclosure of my protected health care information and potentially anonymous usage in a publication. I have the right to revoke this consent in writing; however such a revocation will not be retroactive.

		Please Circle Yes or No	
May we phone you to confirm appointments?		Yes	No
May we leave a detailed message on your	Home phone	Yes	No
	Work phone	Yes	No
	Cell phone	Yes	No
May we discuss your medical condition with any member of your family?		Yes	No

If yes, please name the members allowed:

_____

_____

Signature of Patient or Legal Rep. Witness_____

Printed Name of Patient or Legal Rep. _____Date: _____

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____