Albemarle Family Foot & Ankle

ACKNOWLEDGMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you acknowledge that you have received our Notice of Privacy Practices. This Notice explains how we plan to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. You may refuse to sign this acknowledgment, if you wish.

You have the right to review our Notice of Privacy Practices prior to signing this form. It provides more detail on how we may use and disclose your information. The terms of the Notice of Privacy Practices may change. A current copy may be requested at the front desk.

Signature of patient or responsible party:

_________________________	_________________________	___________
PATIENT NAME	SIGNATURE	DATE

Relationship to patient (if applicable):

_________________________	_________________________
FULL NAME	RELATIONSHIP

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement or receipt of our Notice of Privacy from this patient, but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain acknowledgement.

☐ We weren’t able to communicate with the patient.

☐ Other (Please provide specific details):

____

______________________________	______________
Employee Signature	Date