ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Name: _____
DOB: _____
MRN: _____

By signing this form, I acknowledge that I have received or been offered a copy of the *Notice of Health Information Privacy Practices* booklet, that is required by the Health Insurance Portability and Accountability Act (HIPAA). This booklet describes how health information is used and who can see my medical record and what my rights are with respect to that health information. If I have any questions, I understand I may contact the person or the office that issued me this Notice.

Last Name _____ First Name _____ Date of Birth _____

Patient or Authorized Representative Signature _____ Date _____ Time _____ AM|PM

Interpreter Printed Name _____ Signature _____ Date _____ Time _____ AM|PM

If you are an authorized representative acting on the patient's behalf, complete the following:

Indicate what type of legal authority you have in relation to the patient (i.e. guardian, health care power of attorney). You may need to provide legal evidence upon request:

Authorized Representative Name: _____

Address: _____

_____

Relationship to Patient: _____