



## Patient Acknowledgement of Notice of Privacy Practices

I, \_\_\_\_\_, acknowledge that I have received a copy of this office's Notice of Privacy Practices or that this office's Notice of Privacy Practices was made available to me.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Legal Guardian's name (if patient is a minor)

\_\_\_\_\_  
Legal Guardian's signature

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For office use only:

\_\_\_\_\_ Patient refused a copy of the Notice of Privacy Practices (NPPs)

\_\_\_\_\_ Patient refused to sign Patient Acknowledgement of NPPs

\_\_\_\_\_  
Print name (office staff)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature