# HIPAA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You may refuse to sign this acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

{Signature} {Date}

# AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Due to HIPAA Act of 1996, we are legally required to receive written authorization for any protected health information disclosures to family members or any other person identified by you.

**Please identify the person(s) who are authorized to us to disclose your protect health information.**

We need to advise you that it is the patient's responsibility to notify us of any changes.

1. _____ **Relationship** _____
2. _____ **Relationship** _____
3. _____ **Relationship** _____
4. _____ **Relationship** _____
5. _____ **Relationship** _____

**For Office Use Only**

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other