



**ACKNOWLEDGEMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, acknowledge  
(insert name of patient)

receipt of a copy of Provider's **NOTICE OF PRIVACY PRACTICES**.

Date: \_\_\_\_\_

Patient or Legal Guardian Signature: \_\_\_\_\_

Legal Guardian

Name: \_\_\_\_\_

**Received by:**

\_\_\_\_\_  
(Print Name of Staff Member)

\_\_\_\_\_  
(Signature of Staff Member)

**\*\*\*This completed form must be scanned into the patient's EMR\*\*\***