Privacy Practices Acknowledgement

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Each provider is a separate Entity

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I have received the Notice of Privacy Policy Practices and I have been provided the opportunity to review it.

Name of Patient:_____ DOB:_____

_____ _____ _____
Signature Date Relationship to Patient

For Official Use Only:_____

Date Received	Name of Requestor	Address If Known	Written Request (Y/N)	Purpose	PHI Disclosed	Date Disclosed	Disclosed By

Document initials below:

Name:_____ Initials:____ Name:_____ Initials:____

Name:_____ Initials:____ Name:_____ Initials:____