

HIPAA Privacy Rule Receipt of Notice of Privacy Practices

Written Acknowledgment Form

Acknowledgement of receipt of Information Practices Notice

I, _____ understand that as part of my health care, **All People's Health Center** and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. Acknowledge that I have been provided with and understand that **All People's Health Center** provided a complete description of the use and disclosures of my health information.

I understand that:

I have the right to review **All People's Health Center** Notice of Privacy Practices prior to signing this acknowledgement.

I understand that **All People's Health Center** reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Date

Date

Signature of Individual

Print Name of Individual

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Others (Please Specify)

Date

Signature of Privacy Official