	Acknowledgement of Notice of Privacy Practices Form	**Revision Number: 1.0**

I have been given a copy of this Office's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office's HIPAA Compliance Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date of Birth	
Date of Signature	

For Facility Use Only: ***Complete this section if you are unable to obtain a signature.***

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

   _____

   _____

Completed by	
Signature of Facility Representative	
Date	