Patient Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I, _____ acknowledge I have reviewed & received a copy of this office's *Notice of Privacy Practices* which explains:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my personal health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised and that I am entitled to receive a revised copy of the *Notice of Privacy Practices* upon request.
If I have any questions or complaints, I may contact: **Office Staff of Dr Mabry 703.527.3554**
You may also contact the Secretary of the U. S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U. S. Department of Health and Human Services.

Patient or Personal Representative:

SIGNATURE:_____ **DATE:**_____
PRINT NAME:_____
RELATIONSHIP TO PATIENT:_____

FOR OFFICE USE ONLY

We made good faith effort to obtain acknowledgement of: _____'s receipt of our *Notice of Privacy Practices*. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

_____ Patient refused to sign (date of refusal) _____
_____ Communication barriers prohibited obtaining an acknowledgement.
_____ An emergency situation prevented us from obtaining an acknowledgement.
_____ Other _____

Attempt was made by:_____DATE:_____

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