



**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES and HIPAA COMPLIANCE PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature, that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operators.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home, work or cell? YES NO

May we discuss your medical condition, appointments, or financial concerns with any family member? YES NO

If yes, please name the members allowed:

\_\_\_\_\_

\_\_\_\_\_

This consent was signed by: \_\_\_\_\_  
(PRINT NAME)

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

**For Office Use Only**

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- Other (Please Specify)

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