

I am required to provide you with a copy of my Notice of Privacy Practices, which states how I may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice of Privacy Practices.

You may refuse to sign this acknowledgement, if you wish.

**I acknowledge that I have received a copy of the office's Notice of Privacy Practices.**

\_\_\_\_\_  
Please print your name here

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**IF THE ABOVE IS NOT SIGNED, THIS LOWER SECTION SHOULD BE COMPLETED BY DR. SINGH:**

I have made every effort to obtain written **acknowledgement** of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- I was not able to communicate with the patient.
- Other (*Please provide specific details*)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date