



ADVANCEDTM

Urology Specialists

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy 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 acknowledgment.

HIPAA Acknowledgment of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.

● _____

We weren't able to communicate with the patient.

● _____

Other *(Please provide specific details)*

Employee signature

Date
