14440 Cherry Lane Court, Suite 209
Laurel, MD 20707
(301) 490-7007

HIPAA ACKNOWLEDGEMENT and RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our 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. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

Patient Name: _____

Signature: _____

Date: _____ Relationship to Patient: _____

(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:

___ Patient refused to sign.

___ Due to an emergency situation, it was not possible to obtain an acknowledgement.

___ Unable to communicate with the patient.

___ Other (Please provide specific details):

_____

_____

_____

_____ _____

Employee signature Date