Patient Acknowledgement of Receipt of Privacy Practices Notice

Please Print

I,_____, hereby acknowledge that I have reviewed and
NAME

received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected 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 from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

Pamela Weitzel, D.M.D.
656 Main Street
Contoocook, NH 03229
(603)746-4674
drpamelaweitzel@comcast.net

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: ____/___/____

Name:_____ _____
Please Print

Relationship to Patient: _____

For Office Use

We made a good faith effort to obtain an acknowledge 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) __/___/___.
- ☐ Communications barriers prohibited obtaining an acknowledgement.
- ☐ An emergency situation prevented us from obtaining an acknowledgement.
- ☐ Other_____

Attempt was made by:_____Date::___/___/___

Updated March 20, 2018