

**Acknowledgement of Receipt of notice of Privacy Practices**  
(To be filed in patient's health record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

( ) I choose to restrict all persons other than myself access to my medical records and/or billing information.

( ) I choose to authorize the following individual(s) to have access to my medical records and/or call on behalf of my billing information, please list them below:

\_\_\_\_\_ Spouse  
\_\_\_\_\_ Relationship \_\_\_\_\_  
\_\_\_\_\_ Relationship \_\_\_\_\_

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

Relationship (if not signed by patient) \_\_\_\_\_

**For Internal use only:**

If patient/patient's representative refused to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Date Presented: \_\_\_\_\_

By: \_\_\_\_\_