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ERIN ROYAL MD
Healthcare for All Generations of Alaskans

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(HIPAA)

I, (Patient Name) ____, acknowledge and agree that I am either the patient or the patient's personal representative. I have been offered, received, or viewed a copy of Erin Royal, M.D. LLC's Notice of Privacy Practices. I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

____ ________________

Patient Signature Date

____ ________________

Printed Name of Parent/Legal Guardian/Legal Representative Date

____ ________________

Signature of Parent/Legal Guardian/Legal Representative Date

FOR CLINIC USE ONLY:

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

☐ The Patient/Parent/Legal Guardian/Legal Representative refused to sign

☐ Other (Please provide specific details) ____

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____ ___________________________

Signature of staff member Date