ANCHOR
MEDICAL GROUP

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 Anchor Medical Group'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/Guardian/Legal Representative (if applicable) Date

_____ _____
Signature of Parent/Guardian/Legal Representative (if applicable) Date

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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):

_____

_____

_____ _____
Signature of Staff Member Date

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