



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

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