Name of Client | Date

NOTICE OF PRIVACY PRACTICES RECORD OF ACKNOWLEDGEMENT

We are committed to preserving the privacy and confidentiality of your health information whether created, received, or transmitted by us, or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information, including electronic health information. Copies of our privacy policies and procedures are maintained in the business office. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Effective Date of This Privacy Notice

The effective date of this Privacy Notice is _____.

Changes or Revisions to Our Privacy Notice

We reserve the right to change our *Privacy Notice* at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise or change our *Privacy Notice,* we will post a copy of the new or revised notice in our main lobby. You may obtain a copy of the new/revised *Privacy Notice* from the business office or download a copy from our website (as applicable).

☐ Our Privacy Notice was revised on _____. ☐ No changes since the effective date listed above.

Privacy Notices, Information Restrictions, Record Amendments/Corrections, Disclosures of Information, Revoking an Authorization, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

Should you have any questions concerning our privacy practices, obtaining copies of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your health information, obtaining a listing of the information we disclosed concerning your health information, requests to inspect or copy your medical information, requests that we communicate information about your health matters in a certain way, denial of access to your health information, filing complaints, or any other concerns you may have relative to our privacy practices, please contact:

PROVIDER / PRIVACY CONTACT INFORMATION:

Name of Person to Contact

Provider Name

Address

Telephone Number | Fax Number

YOU MAY ALSO FILE COMPLAINTS WITH:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
Toll-Free 1-877-696-6775

Acknowledgement

I certify that I received a copy of the provider's *Privacy Notice* and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the provider is committed to protecting my health information.

Date	Signature of Client	Printed Name of Client
Date	Signature of Witness	

I certify that I am the authorized representative of _____, and that I have received the *Privacy Notice* on behalf of this individual and that the provider provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the provider is committed to protecting his/her health information.

Date	Signature of Representative	Printed Name of Representative	Relationship to Client
Date	Signature of Witness		

A copy of this document must be provided to the person to whom the *Privacy Notice* was provided and a copy must be filed in the Medical Record.