

Place Patient Label Here

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law. The Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- How I may receive further information about our privacy practices.

SIGNATURE

I hereby acknowledge that I may read or request a copy of CommuniCare Health Centers' Notice of Privacy Practices.

Signature: _____ Date: _____
Patient

Signature: _____ Date: _____
Parent or Patient's Legal Representative (if applicable)

If signed by other than the patient, print name and relationship:

Print Name: _____ Relationship: _____

OFFICE USE ONLY
TO BE COMPLETED WHEN A PATIENT'S SIGNATURE IS NOT OBTAINED

Documentation of Acknowledgement Not Obtained

Patient Name: _____ Date of first visit: _____ Location: _____

1. How was a copy of the Health Center's Notice of Privacy Practices provided?
 - Patient received a paper copy at the time of visit.
 - A copy was mailed or faxed prior to first visit.
2. Describe the good faith efforts made to obtain the patient's signed Acknowledgement of Receipt:
 - Patient was asked to sign the Acknowledgement of Receipt and counseled on our obligations to provide the notice and obtain a signed acknowledgement.
 - Other: _____
3. Describe the reasons why a signed Acknowledgement of Receipt was not obtained:
 - Patient is unwilling or declines to sign.
 - Other: _____

Signature/Title or Department: _____ Date: _____