Your Clinic's Name and
Address Here

Patient's Name:
Medical Record Identifier:
DOB: Gender:
Date of Service:

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you ackowledge that you received the *Notice of Privacy Practices* of the _____. The Notice tells you how we may use and disclose your protected health information. Copies of the current notice are also available on:
_____

Signature of Legal Decision Maker/Patient

Date

Print Name: (Last) (First) (MI)

Relationship to Patient

ACUSE DE RECIBO DEL AVIS DE PRACTICAS DE PRIVACIDAD

Al firmar este formularia, usted reconoce que ha recibido el Aviso de Prácticas de Privacidad del _____. El aviso l informa cómo podemos utilizar y divulgar su información médica protegida. También hay copias del aviso actual disponibles en:
_____

Firma del paciente/ la persona legalmente autorizada para tomar decisiones

Fecha

Nomber (Letra de Molde y Legible)

Parentesco con el Paciente

FOR OFFICE USE ONLY

If written acknowledgment is not obtained, please check reason:

☐ Notive of Privacy Practice Given - Legal Decision Maker Unable to Sign

☐ Notive of Privacy Practice Given - Legal Decision Maker Declined to Sign

☐ Other _____

INTERPRETER USE FOR LIMITED ENGLISH-PROFICIENT, DEAF OR HARD OF HEARING

☐ A Clinic interpreter was used. Date: _____

Signature of in-person interpreter

Print Name or ID#/Company

☐ I do not want to use a free clinic interpreter. _____ (initial)