

Clinic's Name:
Address:

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

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge 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 formulario, usted reconoce que ha recibido el Aviso de Prácticas de Privacidad del _____. El aviso le 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

Nombre (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)