

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____	_____
Name of Patient	Signature of Patient
_____/_____/_____	
Date Signed	
_____	_____
Name of Patient's Personal Representative	Signature of Patient's Personal Representative
_____/_____/_____	
Date Signed	

FOR INTERNAL USE ONLY

_____	_____
Name of Employee	Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained

- Patient was unable to sign.
- Patient refused to sign
- Other _____

____ - ____ (Version: As noted on NPP)

____/____/____ (Date: As noted on NPP)

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**Notice of Privacy Practices (NPP)
Acknowledgement**