



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**ACUSE DE RECIBO DEL AVISO DE PRÁCTICAS DE PRIVACIDAD**

Notice to Patient (Aviso al Paciente):

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

(Le proveemos una copia de nuestro Aviso de Prácticas de Privacidad, donde podemos usar y/o divulgar su información médica. Favor de firmar este formulario donde a firma que recibo esta Comunicado. Usted puede negarse a firmar este formulario, si lo desea.)

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.  
(Yo reconozco que he recibido una copia de la notificación de Prácticas de Privacidad.)

\_\_\_\_\_  
*Please print your name here (Nombre)*

\_\_\_\_\_  
*Signature (Firma)*

\_\_\_\_\_  
*Date (Fecha)*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*)

\_\_\_\_\_  
**Employee signature**

\_\_\_\_\_  
**Date**