I am required to provide you with a copy of my Notice of Privacy Practices, which states how I may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice of Privacy Practices.

You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

IF THE ABOVE IS NOT SIGNED, THIS LOWER SECTION SHOULD BE COMPLETED BY DR. SINGH:

I have made every effort to obtain written **acknowledgement** of receipt of our Notice of Privacy Practices 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.
- I was not able to communicate with the patient.
- Other *(Please provide specific details)*

____

Signature

____

Date

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