Women's WHS
HEALTH SPECIALISTS WELLNESS CENTER

Acknowledgement of Receipt of the Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____ have reviewed the Notice of Privacy Practices as mandated by the Health Insurance Portability and Accountability Act (HIPAA).

I have had my questions answered to my satisfaction.

Please answer the following questions:

May we leave you a DETAILED voicemail message? Yes No

May we discuss your treatment of care with anyone other than you? Yes No

If yes, whom may we communicate with? _____
Relationship to patient _____

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

This acknowledgement should be noted in the patient record and filed accordingly.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practices.

Acknowledgement could not be obtained because:

- ❑ Patient refused to sign
- ❑ Communication barriers prohibited obtaining signature
- ❑ An emergency situation prevented us from obtaining signature
- ❑ Other (Please specify) : _____