



Privacy Notice Acknowledgement

This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Date of Birth: _____

Acknowledgement of receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Privacy Practices Notice from Allen Health Clinic.

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____

Date: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt.)

Describe your good faith effort to obtain the individual's signature on this form:

Describe the reason why the individual would not sign this form:

SIGNATURE (Clinic Representative):

I attest that the above information is correct:

Signature: _____

Date: _____

Print Name: _____

Title: _____

Include this acknowledgement form in the individual's records.

Print Name: _____

Date of Birth: _____

Signed: _____

Date: _____

Witness Signature: _____

Date: _____